

NATIONAL CHILD DAY CARE ASSOCIATION
EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROGRAM



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THE IMPLEMENTATION OF
EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT
IN
CHILD DAY CARE CENTERS
AND
BICENTENNIAL EXPANSION

A M A N U A L
FOR THE TRAINING OF PARAPROFESSIONALS
IN EPSDT AND CHILD DEVELOPMENT PROGRAMS

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Yvonne Brunton Ali, Ph.D.

TABLE OF CONTENTS

	Page
Preface	1
About This Manual	3
INTRODUCTION	5
What is NCDCA?	5
What is EPSDT?	6
The DHEW/DHR/NCDCA/EPSDT Program	7
NCDCA/EPSDT Philosophy of Training	9
 PART I: THE NCDCA/EPSDT TRAINING PROGRAM	 12
Purpose	12
Task Force	12
Selection Process	14
Qualifications of the Trainees	15
Actual Training	16
Training Design	16
Role of Training Coordinator	18
Role of Consultants	19
 PART II: THE TRAINING MANUAL	
CHAPTER ONE: SUGGESTIONS FOR THE TRAINER AND TRAINEE	21
Suggestions for the Trainer	22
Suggestions for the Trainee	27
CHAPTER TWO: HUMAN RELATIONS	29
Purpose	30
Level A: The Self/Internal	30
Objectives	30
Methods of Instruction	30
Resources	35
Assessment	36
Level B: Communication	37
Objectives	37
Methods of Communication	37
Stages of Communication	38
Methods of Instruction	39
Resources	40
Assessment	41

	Page
Level C: Other/External	41
Objectives	41
Methods of Instruction	42
Resources	43
Assessment	44
 CHAPTER THREE: MEDICAL	 45
Introduction	46
Purpose	46
Performance/Outcome Objectives	46
Psychomotor Domain	47
Affective Domain	47
Cognitive Domain	47
 MODULE ONE: Preparing The Child For Screening	 48
Objective	48
Secondary Objectives	48
Content/Discussion	48
What You Need To Know	49
What The Doctor Needs	49
What You Need To Do/What To Tell The Child	49
 MODULE TWO: Growth and Development in Children	 50
Objective	50
Secondary Objectives	50
Content/Discussion	51
Introduction to Growth	51
Growth Chart	53
Introduction to Development	54
What You Need	57
What You Need To Know	57
What You Need To Do/What To Tell The Child	57
 MODULE THREE: Anatomy and Physiology of Man	 58
 MODULE FOUR: Vital Signs and Laboratory Work	 58
Objective	58
Secondary Objectives	58
Cardiac System	59
Diagram of How Blood Flows Into the Heart	59
Respiratory System	60
Digestive System	61
Genito-Urinary Tract	63
Nervous System	64

	Page
Skeletal System.....	66
Muscular System.....	67
Endocrine System.....	67
Taking the Vital Signs.....	69
Temperature.....	69
Body Temperature.....	69
Taking the Temperature.....	69
What is a Fever.....	69
What is a Thermometer.....	70
What You Need.....	70
What You Need To Know.....	70
What You Need To Do/What To Tell The Child.....	71
Pulse.....	72
What is the Pulse.....	72
What You Need To Do/What To Tell The Child.....	73
Respiration.....	74
What is Respiration.....	74
What Influences Respiration.....	74
Why Take Respiration.....	74
What You Need.....	74
What You Need To Do/What You Don't Tell The Child.....	74
Collection of a Clean Catch Urine Specimen.....	75
Why Take a Urine Specimen.....	75
What is Testing Urine Called.....	75
What Do You Use.....	75
What You Need.....	76
What You Need To Do/What To Tell The Child.....	76
Blood Testing.....	77
What You Need To Do/What To Tell The Child.....	76
 MODULE FIVE: The Eye and Eye Screening.....	 78
Objective.....	78
Secondary Objectives.....	78
Introduction.....	79
What is the Eye.....	79
Parts of the Eye.....	79
How We See.....	80
Why Do We Need Eye Examinations.....	80
Diagram of the Eye.....	81
What Are Some Common Eye Problems.....	82
Amblyopia.....	82
Strabismus.....	82
Infections of the Eye.....	82
Pink Eye.....	82
Stye.....	83
Trachoma.....	83
Red Eye.....	83
Iritis.....	83
Acute Glaucoma.....	83

	Page
Objective Three	144
Content	144
Glossary of Terms Uses In Mental Health	145
Methods of Instruction	155
Resources	155
Objective Four	156
Content	156
Supportive Framework	156
Methods of Instruction	159
Resources	160
Method of Evaluation	161
Observation Instrument	163
Definitions for Items in Observation Instrument	165
Objective Five	167
Content	167
Methods of Instruction	168
A Guide for Observation of Behaviors	169
Resources	172
Method of Evaluation	173
Objective Six	173
Discussion	173
Meeting Common Problems of Children	175
Therapeutic Sentencing	178
Objective Seven	180
Discussion	180

CHAPTER FIVE: CHILD DEVELOPMENT182

Introduction	182
Objectives	182
Objective One	183
Discussion	183
Chart of Normative Behaviors 0 - 11 years	184
Pre-Adolescence and Adolescence	199
Methods of Instruction	203
Methods of Evaluation	204
List of References	204
Objective Two	205
Discussion	205
Introductory Remarks	205
Jean Piaget's Theory of Cognitive Development	205
Schemata	205
Assimilation	206
Accommodation	206
Equilibrium	207
Summary	207
Functional Invariants	207
Intelligence	208
Action	208
Periods of Development	208

	Page
Methods of Instruction	209
Methods of Evaluation	209
Lists of Resources	210
Objective Three	210
Discussion	210
Introductory Remarks	211
Erik Erikson: The Eight Stages In The Life Cycle	211
Methods of Instruction	213
Methods of Evaluation	213
Resources	213
Objective Four	214
Discussion	214
Introduction	214
Testing Strategies	214
Qualifications of the Examiner	214
Familiarity with the Test	215
Familiarity with the Child	215
Physical Setting	215
Developing Rapport	215
Administration Time	215
Introducing the Test	216
Classification of Tests	216
Testing Techniques	217
Projective Techniques	217
Rating Scales	217
Self-Report Measures	217
Observational Procedures	217
Some Problems Involved with Testing	218
Method of Instruction	219
Methods of Evaluation	219
Resources	219
Objective Five	220
Discussion	220
Reference Sources	221
Objective Six	221
Discussion	221
Glossary of Terms Uses in Child Development	221

PREFACE

The Early and Periodic Screening, Diagnosis and Treatment program conducted by National Child Day Care Association benefitted thousands of children and families in Washington, D.C. The training program for paraprofessionals has been effective both from a program point of view and for the individuals concerned. The Association was able to hire four of the twelve trainees. Of the others who successfully completed the training, three went on to college, two have jobs in other social service agencies, two were pregnant and are now home with their babies and one is working outside of the field.

Your agency or community can adapt this program to fit your needs. It is easily replicable and the costs are reasonable. The biggest return on the money invested comes from having available a staff which is capable of assuming some tasks that professionals are pleased to share. This relieves the budget burden for high salaried staff but maintains quality in programming.

Writing this manual has been a massive job for Dr. Ali. Plans called for the trainees to keep notebooks filled with the essence of their activities on a daily basis. The translation of this information into a meaningful document should help to make this a living experience for the reader, the trainer, and the trainee.

This manual, and others like it, will be open to revision and updating as new experiences and new knowledge about ourselves and about training become available. With this edition, we are exploring new fields with the hope of having meaningful impact in the area of social services. This training brings new dimensions to the lives of people who have hopes of greater personal fulfillment, but who have, thus far, only dreamed it could come true.

Thomas C. Taylor,
Executive Director



*Children are the worlds
most valuable resource
and it's best hope for the future.
John F. Kennedy.*

ABOUT THIS MANUAL

This manual is intended to be a comprehensive document that will facilitate training paraprofessionals. Originally, the focus was on paraprofessionals who will be working in EPSDT programs. The final document, however, is a valuable tool for persons in all programs that serve children. It covers, in some detail, four extremely relevant areas: Human relations, medical concepts, emotional development and child development. It not only gives content in these areas, but also provides the trainer with practical suggestions for the "how to train" and lists a variety of additional resources. Besides providing new information for the paraprofessional, this manual is at least a comprehensive review for the professional.

For the trainer: Before using this manual you should become familiar with its contents. Look for its strengths and its limitations. The various sections of the manual are not intended to cover a particular area in total. In many instances you will need additional information and/or resource materials before proceeding with training. Use this manual to its best advantage. You are free to reproduce sections of it for training purposes only. You are also free to contact me if I can provide any additional help or clarify any issues.

For the trainee: My interest is in sharing my experiences and knowledge with you. Hopefully in this manner, I will achieve my primary goal which is helping people increase their skills so that they are better able to serve children positively.

Writing this manual has been a learning and growing experience for me. I hope you will benefit from using it.

Good luck and R E A D O N.....

Yvonne Brunton Ali. Ph.D.



A man never stands so
tall as when he stoops
to help a child.

Horace Height.

INTRODUCTION

WHAT IS NCDCA?

The National Child Day Care Association (NCDCA) was originally incorporated in 1964. It is a private, non-profit organization whose purpose is to provide good, comprehensive services to children ages two-and-a-half to fourteen.

NCDCA operates fifteen preschool centers and five extended day care centers, serving a total of 1,215 children. In addition, NCDCA operates a special education center for preschool children with learning and emotional problems.

NCDCA has operated several special programs and demonstration centers. The special programs included the four year Early and Periodic Screening Diagnosis and Treatment (EPSDT) research and demonstration program, and the Handicapped Children's Early Education Program - (HCEEP). The demonstration centers included the Department of Labor (DOL) Day Care Center and National Institute of Education (NIE) Day Care Center. These centers were for children of employees of DOL and NIE respectively.

Funding for the NCDCA programs comes from various subdivisions of the Department of Health, Education and Welfare (DHEW) and from the District of Columbia, Department of Human Resources (DC-DHR). A total of eight Head Start preschool centers are funded by DHEW -Administration of Children, Youth and Families (ACYF) formerly Office of Child Development (OCD) through the United Planning Organization - (UPO). The other seven preschool centers and extended day care centers are funded by the DC-DHR.

NCDCA is governed by a forty-eight member Board of Directors, sixteen of whom are parents who have children currently enrolled in NCDCA centers. A Parent Policy Board was formed in 1967. This committee is composed of parents representing the various centers. The purpose of the Parent Policy Committee is to provide a workable avenue through which parents can have administrative and program input at all levels.

WHAT IS EPSDT?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) was a 1967 congressional attempt to provide comprehensive health care for the nation's estimated thirteen million medicaid eligible children between the ages of infancy through twenty-one. Congress, in looking at the amount of money that had been spent on medicaid, determined that the majority of the money had been spent for treatment rather than for prevention. Congress therefore suggested, and later mandated, that all states provide EPSDT services.

The basic concept of EPSDT can be described in four words - comprehensive, preventive health care. The advent of EPSDT brought about a revolution in the term "comprehensive health care." For EPSDT, comprehensive health care incorporates the medical, dental, developmental and mental aspects of health care thus requiring the integration of several disciplines - medicine, psychiatry, psychology, special education, general education and social services.

The word "preventive" places emphasis on periodic screening or assessment. For the medicaid eligible population this was a new concept. Records show that traditionally the vast majority of the EPSDT eligible population received sporadic, episodic medical care on an "as need" or emergency basis. The EPSDT philosophy encourages an on-going program of total health care placing emphasis on screening, diagnosis and treatment of all problems, if possible, before they become major.

Treatment is a key word in the EPSDT concept. Why screen and diagnose problems if the necessary treatment is not forthcoming? The EPSDT philosophy, therefore, places heavy emphasis on providing the necessary treatment for any detected problem.

THE DHEW/DHR/NCDCA/EPSDT PROGRAM

Implementation of a program as massive as EPSDT brings with it several problems centering primarily around outreach, implementation, manpower and monetary resources.

In fiscal 1972 and 1973, the Department of Health, Education and Welfare (DHEW), realizing the problems that states were having with EPSDT implementation, decided to fund several research and demonstration programs. It was hoped that this research would indicate ways of providing technical assistance to states.

This project, "The Implementation of Early and Periodic Screening Diagnosis and Treatment in Child Day Care Centers and Bicentennial Expansion," was one of the pioneer research and demonstration programs. It was funded by the Office of Social Rehabilitation Services (SRS) of DHEW. Since the funding was part of the 1115 Social Security Act, which makes funds available for states, it was necessary for the monies to be channeled through the state agency. As a result, the project was funded through the District of Columbia, Department of Human Resources (DC-DHR) and administered by the National Child Day Care Association (NCDCA) of Washington, D. C.

The initial grant award totaled \$215,297 for the period July 1, 1973 through June 30, 1974 but funds did not become available until October 1, 1973. At that time the program's intent was to provide complete medical and dental screening, diagnosis and treatment services for the 750 children enrolled in NCDCA's eight model cities preschool and six day care after school centers. In addition, the project provided developmental and emotional screening, diagnosis and treatment services for the 450 pre-school children enrolled in the aforementioned eight NCDCA pre-school centers located in the model cities area of Washington, D. C.

In June, 1976 the project was chosen by HEW to be the bicentennial showcase program and was subsequently expanded. Funding increased to about \$780,000 and a population of 2,700 children, 2,000 of whom were public school enrollees, were

served. Over a four year period, this project has been funded at a cost totaling \$2,270,000.

The medical and dental aspects of the program were immediately expanded to include the public school children. Strategic persons in the D. C. School System and DHR felt, however, that a feasibility study should be conducted prior to implementing a developmental program in the schools. The expressed purpose of such a study was to determine the need for a developmental program in the public schools and the feasibility of an outside agency (in this case NCDCA) implementing such a program. Based on the results of the feasibility study, the project began operating a developmental psychoeducational program in two D. C. Public Schools in fiscal year 1977.

Another important aspect of the bicentennial project was the development and implementation of a paraprofessional training program. The purpose of this facet of the EPSDT project was twofold. It's intent was first to explore the possibility of increasing available EPSDT personnel and expanding monetary resources by training paraprofessionals to perform specific jobs in all aspects of EPSDT; second, to write a training manual that could be used by other agencies and institutions which are charged with implementing EPSDT.

The major portion of the DHEW/DHR/NCDCA/EPSDT project terminated on June 30, 1977. It was expected that the developmental public school aspects of the program would be funded for an additional year. That component did not begin until January 30, 1977, and reliable, valid data would not have been available for twelve to eighteen months following implementation.

However, due to DHEW's extremely tight budget combined with their policy not to refund research and demonstration projects beyond three years, the entire project was terminated in November, 1977.

NCDCA/EPST PHILOSOPHY OF TRAINING

The philosophy of training incorporated by the NCDCA/EPST program is eclectic and draws upon the works of several theorists and practitioners. Perhaps the most influential theorist is Jean Piaget. The Piagetian theory stipulates that learning involves the processes of accommodation and assimilation. An individual accommodates to new knowledge and assimilates it into his already existing repertoire. According to Piaget, this process can only be achieved by means of active participation in one's environment.

The postulates of William Glasser (1969) also influence the project's philosophy. Glasser contends that education, if it is to be effective, must become more reality oriented. The student's learning experiences must be of interest and practical importance to him, and the learner must be actively involved in the educative process.

The humanistic educational viewpoint, which comprises the work of many individuals, among them Holt (1974), Moustakas (1972) and Rogers (1961) theorize that education must bring into harmony the affective and cognitive domains. An important concept of the humanistic approach is that education should be open ended and should be made relevant to the learner. This concept is synonymous with Glasser's primary thesis of realism and relevance in learning.

Many of the mental health theories also influence the project's philosophy. The basic concepts underlying the Transactional Analysis theory, and the principles of Reality Therapy are seen as important. It is the belief of many of the individuals connected with the project that an individual must be able to look at and understand the self if he/she is going to relate effectively with others.

The project's philosophy of training is also influenced by the fact that for many young people, the traditional approach to education is not the means to successful end. Many drop out of school altogether; some attend school physically but little academic learning takes place.

If it is to be successful, the training program has to be student oriented with input at all levels. Learning has to take place simultaneously at the cognitive and the affective levels. Content and process have to be interesting to and relevant for the student.

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PART I

**THE NCDCA/EPSTD
TRAINING PROGRAM**

THE NCDCA/EPSTD TRAINING PROGRAM

PURPOSE

The primary purpose of the DHEW/DHR/NCDCA/EPSTD training program was to determine whether or not paraprofessionals could be effectively trained to perform tasks necessary for EPSTD implementation. The thinking was that staff resources could be cost-effectively expanded if paraprofessionals could be trained to fill some positions heretofore held by professionals.

TASK FORCE

Prior to actual implementation of the training effort a task force of fourteen individuals, experts in the fields of pediatrics, psychiatry, psychology, teacher training, elementary education, early childhood education, special education, nursing, evaluation and research, was convened. The purpose of the task force was to:

- Identify important variables to be considered when implementing a training and research program.

- Discuss implementation techniques.

- Determine models, concepts, and issues involved in training paraprofessionals for competence.

- Identify appropriate areas and skills that needed to be taught.

- Identify existing training models.

- Develop a training plan.

- Determine the concept and composition of a laboratory school.

The primary objective of the task force was to evolve a training model for a program that was mindful of existing instructional models and trends in training. The rationale for setting up a task force was that adequate and effective planning leads to more efficient implementation. In addition, such input eliminates some of the trial and error usually associated with new programs, and avoids possible duplication of services.

The task force consultants presented position papers in response to the following questions they received prior to the task force meeting:

1. What specific tasks do you think paraprofessionals can be trained to do in the EPSDT program? What would be involved in training paraprofessionals for these tasks?
2. What effective models for paraprofessional training are you familiar with? What aspects of these models are applicable to the EPSDT program?
3. What would you see as a proper blend of theory and practical experiences for paraprofessionals? Specify some of the experiences trainees should have. What theoretical base should they have?
4. What is competency? How would you evaluate competency?
5. What kind of evaluation strategies should be encompassed by the program? How and when should these strategies be employed?
6. What do you see as some of the obstacles to paraprofessional training? How can these obstacles be overcome?
7. How can upward mobility be built into paraprofessional training?
8. How can the training program help raise the paraprofessional's level of self-motivation?

The task force meeting was a very productive one. Many recommendations for training design and implementation were made. The following are the most pertinent recommendations.

1. Paraprofessionals should not be given abstract theoretical information, but relevant practical experiences flowing from a theoretical base.
2. Whatever theories are presented to paraprofessional trainees should be tied into real experiences that occur with children.
3. Training in tutorial and observational roles should precede training in screening roles.
4. Desensitization about testing is necessary in order to remove potential sources of bias.
5. Training of paraprofessionals should be divided between generalized and specialized training. The trainee should have some months of basic training, followed by a period of exposure to each component of the program, and finally some months of specialized training.

6. Time should be allotted for trainees to get together to talk about their day and evaluate their experiences under circumstances in which they do not feel threatened.
7. The evaluation should be characteristically multidimensional. The focus should be on program effectiveness. Daily on-site evaluation is necessary.
8. Evaluation of paraprofessional competencies should include ways of assessing competencies by actual performance as well as mechanisms for making changes when change is necessary.
9. The role of trainer is a vitally important one. The trainer should be carefully screened to determine that person's ability to relate to paraprofessionals. Emotional maturity is an important factor for the trainer.
10. There should be an ombudsman who can act as arbitrator in the event that interactional and/or interpersonal difficulties should arise.
11. The program should be humanistic with a sense of self-worth provided to the participants as an integral part of the paraprofessional learning. The paraprofessional has the right to have input in the program.

Based on task force recommendations, it was determined that a modular structure would best suit the needs of the paraprofessional training program. The modular structure provided exposure to all components of the EPSDT program. These sub-systems were medical, developmental, emotional, and social. Additionally, a laboratory school was operated to provide on-site practicum experience for the trainees.

SELECTION PROCESS

The process of selecting the trainees was a very important one. We chose individuals with certain qualities, not the least of which were a genuine love for children and an ability to work with people - (children and adults) in a helpful, supportive fashion. The process used to select the trainees for the DHEW/DHR/NCDCA/EPSDT program was a unique and very effective one. For the benefit of those who may choose to use this process it will be described briefly.

The group interview technique was used. Because of the numbers of qualified applicants four group interviews were held for each training session. The number of applicants was reduced after each interview. Each group interview lasted for approximately three hours. The large groups were sub-divided into smaller groups by means of a randomized seating arrangement. The first task for each of the small groups was to

select a leader. Fifteen minutes was allotted to this process and the applicants were free to use any method they chose to select the leader. This process was monitored by ten members of the NCDCA-EPSDT staff, including the project director, the training coordinator and the consultant psychiatrist.

Each of the groups was then given a question to answer. The groups were given fifteen minutes to discuss the question and formulate an answer, after which one member of each small group presented the group's answer. Time was then allotted for some large group discussion. The small group activity was again monitored as described earlier.

The next step of the interview process involved role plays. Each group was given a role play situation. There were enough characters in each situation so that every member of the group could participate. Again fifteen minutes were allotted for the groups to determine roles and plan strategies. Each small group was then required to "act out" the situation for the larger group. No follow-up discussion was allowed.

This process was followed for each of the four interview sessions until finally ten individuals were chosen. These ten persons were individually interviewed by the training coordinator and the final selection of seven and six respectively was made jointly by the project director and the training coordinator.

QUALIFICATIONS OF THE TRAINEES

The minimal requirements for acceptance into the training program were as follows:

1. Ability to read and write.
2. High school diploma or equivalency preferred but not required.
3. No college experience allowed.
4. Demonstrated ability, as observed through the interview process, to deal with people in a supportive fashion, and to accept the philosophy of NCDCA and EPSDT.
5. Demonstrated ability, as observed through the interview process, to work with children in a patient supportive manner.
6. Ability to verbalize.
7. No previous work experience required.
8. Desire to learn new skills and techniques.

ACTUAL TRAINING

The project implemented two training sessions, each for a period of six months. While there were some differences between the two sessions in the day to day processes, the basic practical and theoretical content was the same for both groups. The subjects areas covered were:

1. Child Development from infancy through age thirteen.
2. Basic developmental stages as outlined by Erik Erikson and Selma Fraiberg.
3. Stages of emotional growth and development as outlined by Sigmund Freud.
4. Ego functions.
5. Testing: Problems and techniques.
6. The Developmental Systems Analysis (DSA) locally developed instrument for testing preschool children.
7. Physical growth and development.
8. Anatomy and physiology.
9. Immunizations and laboratory tests.
10. First Aid and prevention of illness.
11. Assisting the doctor.
12. The affective aspects of health care; attitudes regarding pain and fear in children, procedures involving needles, blood work, etc.
13. Speech and hearing.
14. Human Relations

TRAINING DESIGN

The training was designed so that instruction consisted of simultaneous didactic and practicum sessions in all of the subsystems of EPSDT as well as in the general areas of communication, supportive techniques and other areas. To this end the training was divided into several phases.

Phase I - Human Relations

The first week of the training program dealt with the subject of human relations. The goals were to help the trainees get to know themselves better, to cohere as a group and learn to communicate openly within the group, to see themselves as part of the staff of the NCDCA/EPSTD program, and NCDCA as a whole, and to communicate with people in general. The philosophy, policies and procedures of NCDCA, EPSTD and the NCDCA/EPSTD program were covered during this week.

Phase 2 - Child Development

Working in an EPSTD program requires working with children. The philosophy of the NCDCA/EPSTD program was that any individual who desires to work with children in any capacity must understand and internalize the basic principles of good child development. He/she must know what is expected behavior for children at various ages. He/she must learn techniques necessary to work with children in a supportive, positive fashion. A total of six weeks was spent on child development. The stages of intellectual (cognitive), emotional (affective) and social (interpersonal) development were dealt with. Attention was paid to various theorists, among them, Piaget, Erikson and Freud. The trainees were taught supportive techniques to be used when working with children. Emphasis was placed on the kinds of situations that may arise when implementing the various subsystems of EPSTD.

Phase 3 - General EPSTD Training

This phase involved studying content in all components of EPSTD: medical, developmental, emotional and social. A total of eight weeks was spent, two on each component area. The content was analagous to an introductory course in each of the content areas. The objective was to expose trainees to all areas of the program for the purpose of measuring interest and ability in a specific area. At the end of this eight week period the trainees were placed in a specific component of the program where they received specialized training. The decision for placement was made jointly by the trainee, the project director, the training coordinator and the component leader.

Phase 4 - Specialized Training

A total of eight weeks was spent on specialized training. Each trainee was assigned to one of the component areas. They worked as assistants during the mornings - 9:30 a.m. to 1:00 p.m. During the afternoon they participated in didactic workshops, or were given other theoretical assignments. Often four workshops, one in each component area, were being conducted simultaneously. Although the workshops were planned primarily for the trainees, they were open to other staff members who wished to attend. Some general topic areas were reiterated during this eight week time period. These topics included: Observational techniques, supportive techniques, testing and screening techniques. Time was allotted daily for the trainees to get together as a group and discuss and evaluate the day's experiences and activities.

ROLE OF TRAINING COORDINATOR

The training coordinator functioned in several capacities. Her primary role was to coordinate the training program. This involved planning and designing the training program in consultation with the project director; contacting outside agencies as a means of obtaining diverse practicum sites for the trainees; contracting with consultants to conduct didactic workshops; arranging schedules; working with various EPSDT staff members who were developing training modules; observing, evaluating and, when necessary, counseling the trainees. The coordinator's role did not require conducting training workshops, but in many instances her input was necessary.

The training coordinator is crucial to the success of any training program and should be carefully chosen. Often he/she must serve as a bridge between the trainees and the other staff members, both within and without the agency. The coordinator must have the emotional maturity necessary to deal objectively with interpersonal problems and conflicts that may arise. She/he must be able to help the trainees mature emotionally and professionally. She/he must have the ability to become personally involved while not bringing personal problems to the group. She/he must become a member of the group while still maintaining the respect of subordinates.

ROLE OF CONSULTANTS

The consultants used in the program were experts in their respective fields. Their primary function was to conduct didactic workshops in specific subject areas. They were also required to develop, with input from the project director, tests in the specific content area, and to administer and score these tests.

Besides having professional knowledge and expertise, the consultants had good teaching skills; they were sensitive to the needs of people, and they had the ability to work well with paraprofessionals. In addition, the consultants had to accept the philosophy of NCDCA and of the EPSDT program. Accepting the philosophy was a crucial point. The success of the training program was dependent on everyone involved being philosophically compatible. This insured that the input given to the trainees was consistent not conflictual.

PART II

THE TRAINING MANUAL



*A mind is a terrible
thing to waste.*

United Negro College Fund.

CHAPTER ONE

SUGGESTIONS FOR THE TRAINER AND TRAINEE

CHAPTER ONE

SUGGESTIONS FOR THE TRAINER

- I. It is important that training time be a simultaneous blend of didactic and experimental workshops. This helps to reinforce the theoretical knowledge being learned. For example, if training is centered on health care for children, it is essential that the trainees have a health care facility in which they can observe and participate in the delivery of said care. This serves to reinforce learning and increase the validity of the training event.
- II. During training, the didactic workshops should be offered by various experts in their respective fields. If this is done the training coordinator will not be overwhelmed with trying to deliver all necessary services to the trainees. In addition, EPSDT is a very diverse program requiring a wide variety of content. No one person is expected to be an expert in all areas included in EPSDT.
- III. Placement of trainees in a particular subsystem of EPSDT should be a group decision. A group decision-making body helps to eliminate unsatisfactory placement of trainees and reduce negative reactions to placement.
- IV. Once the trainees have been placed in the component in which they will work permanently, they should no longer be under the direct supervision of the training coordinator. They are now under the supervision of the component leader. The trainees and training coordinator should still meet on as regular a basis as necessary. It is important to note that at the point at which the trainees are placed, separation problems between trainees and training coordinator may arise. Even though a group decision is made in order to ensure the best possible placement for the trainees, separation problems do occur. The environment of the trainees is different although familiar. They are no longer trainees per se, but paraprofessionals completing on-the-job training. Below are some steps the training coordinator can take to help decrease separation problems.

- A. Instill a sense of accomplishment in the trainees.
 - B. Do not indulge the trainees in their adjustment problems, real or imagined. This places their component leader in a negative position.
 - C. Do not indulge in trainer problems. Insist that the trainees must work any problems through with their component leader.
 - D. Allow trainees to make decisions of which they are capable throughout training.
 - E. Meet with trainees' component leaders to discuss progress of trainees not to make accusations on their behalf.
 - F. Recognize that the supervisory role as training coordinator has ended with trainee placement. LET THEM GO.
- V. Organization is the key to a successful training program. If properly organized, the training program flows smoothly and the work load of the training coordinator is lessened. The three most important phases of any training event are:
- A. Planning for training - the following criterion should be met:
 - 1. Set objectives: Objectives should be clearly defined and should be attainable. Separate objectives should be set for each didactic workshop and practicum experience.
 - 2. Establish content: Specific content should be reality based. College courses are not being conducted. The goal is to provide trainees with specific knowledge and skills.
 - 3. Select trainers: State objectives and desired content clearly to the consultant trainer. Objectives must be met and someone else has to ensure they are met. Give them the benefit of your thinking.
 - 4. Determine specific teaching methods to be used.
 - 5. Design and/or order training materials.
 - B. Preparing for the training:
 - 1. Establish time frames keeping in mind that the attention span for an average student is about one-and-a-half hours. If content for a specific workshop requires approximately three hours, plan the time so that coffee breaks are given. Always allow time for immediate follow-up discussion.

2. Arrange for equipment, including audiovisual aides, rooms and materials. Be sure everything is available before the scheduled time for the session. It is very distracting for everyone concerned if the leader is looking for materials during the training session.
3. Review content with trainers or practice training yourself.
4. Review all films or film strips prior to the training event. Allow enough time to make any changes that may be necessary.

C. Conducting the training:

1. Train: The didactic sessions are usually conducted by an outside consultant but the training coordinator should be familiar with the content. For the practicum experiences the training coordinator must be a good role model. Role modeling involves demonstrating effective techniques for the trainees.
2. Observe: The training coordinator must be an acute observer. She/he must be aware of everything that is taking place during the training, including the reactions of individual trainees.
3. Make anecdotal records: A great deal of information is being shared. The training coordinator must have this information available for recall, review and evaluation.
4. Evaluate and review: Evaluation helps to point up those areas in which knowledge was acquired, and those areas in which knowledge was missed. Review serves as an aid to reinforcing learning.
5. Discuss: It is crucial that time be allotted for follow-up discussion with the trainees after each training event.

VI. In planning, preparing and conducting any training event, it is essential to prepare for the proper atmosphere. Atmosphere is defined as the psychological environment. In a training event which extends over a lengthy time period, it is best to work at creating an informal atmosphere. The first step toward creating an informal atmosphere is to design the physical environment to meet that need. Listed below are the steps needed:

- A. Room size: The room should be of a size that can comfortably accommodate the training group and any materials needed. It should not be overly large. A too large room creates a feeling of distance among participants.

- B. Room decor: The room lighting should be bright enough to alleviate eye strain. If possible, use rooms which do not have objects that draw attention away from the training event. Items in rooms should be relevant to the training event.
- C. Room furnishing: Furnishings should be spacious enough to allow participants room for writing and movement.
- D. Seating arrangement: Seats should be arranged so that all participants are facing each other. A circular or semi-circular chair arrangement allows this.

VII Once the physical environment for training sessions is set up, there are still techniques to be used that help to create a positive psychological environment. These are called ice breaking techniques. Their purpose is to establish a feeling of camaraderie among group participants. Some ice breakers are described below:

A. Getting To Know You

Each participant is asked to turn to their neighbor and spend five minutes interchanging information concerning themselves. At the end of five minutes the training coordinator calls time. The coordinator asks each participant to relate what their neighbor has told them to the group. After each person has done this, the coordinator asks the participants to turn to their neighbors for five more minutes to interchange information. This time the coordinator instructs the group not to discuss information such as name, age, marital status, number of children, place of birth, and educational background. At the end of five minutes, time is called and participants again relay information to the group about their partner. The participants are again asked to turn to their neighbors for five more minutes. This time the information not to be discussed is hobbies, leisure time activities, parents, or present home. At the end of five minutes participants relay information to the group. After the third interchange,

each participant is called upon at least once to relay to the group something about a participant other than his partner.

Group size: The group should not contain more than six participants. If more than six, the group should be broken into smaller groups and each participant relay information about one of his group members.

B. Introduce Me

Each participant is instructed to turn to his neighbor and introduce his/her self. Introduction should include more than the person's name. At the end of three minutes, participants are asked to introduce their partner to the group. The training coordinator should participate in this activity.

Group Size: Ten to twelve is ideal. If more than twelve, the group should be broken down into two or more groups.

C. Who Was That?

After trainees are seated, the training coordinator has an individual run in and out of the room dressed in some type of costume. The coordinator then asks the trainees questions relevant to the individual's costume.

Sample questions to be asked are:

1. Was that a man or a woman?
2. What color were the clothes?
3. What did the person have in his/her hands?
4. What did they have on their feet?
5. Were they wearing glasses?

Group size: Ten to twenty.

These are just a few icebreakers to be used. Hopefully, they will generate thoughts to produce icebreakers which are more suitable to the group being trained.

SUGGESTIONS FOR THE TRAINEE

- I. You are employed. You are being paid while in training—you are not paying for the training. You should regard this as full time employment with all the responsibilities that full time employment brings. Basic job responsibilities include:
 - A. Punctuality: It is important that you come to work on time every day.
 - B. Regularity: You should report to work every day. In the event of illness, you must inform your supervisor prior to the time that you are due to report to work. You should take off only in the event of illness or emergency.
 - C. Alertness: You must come to work alert and motivated to work. Tiredness or lack of interest on the job is frowned upon by supervisors.
 - D. Attitude: You must be pleasant, positive and friendly on the job. A negative, hostile attitude will make things unpleasant for you and your coworkers. A smile and a pleasant greeting go a long way. You are showing respect for yourself and others when you say "hello," "good morning" or "thank you."
- II. Your success in the training program is important to your future. If you are to secure a job in the area in which you have been trained you must achieve success in the training program. Achieving success in the training program means gaining knowledge and skills and being able to practically apply the knowledge and skills you have learned.
- III. Ask questions. When you do not understand something or you need clarification, ask the person in charge. Asking questions is a sign of intelligence not ignorance. One of the ways that an individual learns is by asking questions.
- IV. Accept criticism. Your trainer is there to help you. Remember no one always does everything right all the time. One way to correct your error is to have someone point it out to you and discuss with you ways in which you can improve.

- V. While you may become friends with people with whom you work, learn to separate your personal relations from your job relationships. Do not spend your time on the job discussing what happened the night before. While on the job, deal with the task at hand.
- VI. Do not gossip or spread and encourage idle rumors. If someone attempts to talk to you about problems with a co-worker, suggest that they talk with that person, or with the supervisor. You cannot solve the problem.
- VII. Do not let your personal problems affect the job. If you are having difficulty you may want to talk with your supervisor. He/she can direct you to someone who can help you. Do not discuss your personal problems with all of your co-workers. Choose your confidants carefully.
- VIII. Always be open and willing to learn. Knowledge is your biggest key to success.
- IX. Be cooperative. Your cooperation helps to make things easier for yourself and for your co-workers. Remember, any job is a team effort.
- X. When you are employed you become a member of that agency. If you down grade that agency, you are downgrading yourself. Disagreements are to be expected, but discuss those disagreements with the person in charge. Be loyal - do not spread negative rumors about the agency.

CHAPTER TWO
HUMAN RELATIONS

WITH INPUT FROM:
James M. Ballard, Ph.D.
Janice Lyles, M.A.

CHAPTER TWO

HUMAN RELATIONS

PURPOSE

The purpose of this dimension of the training is to give the students an awareness of human relations and to facilitate the development of sensitivities toward self, others, and the process of communication between self and others. This dimension is of foremost importance and permeates all of the training dimensions. The topic of human relations is divided into three sections: Level A: The Self/Internal; Level B: Communication, Level C: Other/External.

LEVEL A: THE SELF/INTERNAL

This refers to the individual as he/she perceives and reacts to him/her self. It involves getting to know and understand one's self as a social being. It further involves helping the individual understand how his/her actions and reactions effect those with whom he/she comes into contact.

OBJECTIVES

1. The development of a healthy self-concept.
2. Awareness of messages sent by physical appearance and body language.
3. Ability to control body language and make body language applicable to intent.
4. Ability to use common sense and logic.
5. Establishment of a reasonable system of socially acceptable limits and rules to be understood, honored and protected by all involved.
6. Ability to understand and accept one's own feelings and reactions.
7. Ability to understand and accept the feelings and reactions of others.

METHODS OF INSTRUCTION

1. Group Marathon. Marathons are often twenty-four to forty-eight hour sessions, but they can be run for eight to ten hours. Initially the eight to ten hour marathon may be most applicable for a training program. The trainer must get to know the group to be able to make decisions about the time span of the marathon that would be most effective for the group.

The primary objective of the marathon is to help develop the awareness of self in relation to others. The first step is to help the individual get in touch with self. This involves the ability to understand and accept the responsibility for one's own actions, words and feelings.

A marathon must be conducted by a qualified psychiatrist, psychologist or group therapist who has experience in sensitivity training and group dynamics. The process of getting in touch with self can be a painful one that may involve disclosing information, conflicts and feelings which an individual cannot resolve alone. A psychiatrist, psychologist or group therapist must be readily available to provide emotional support for the individual and group.

The following are some icebreakers, games and exercises that are often used in a marathon. Some of these can be used by the trainer as introductory or follow up activities to the work done by the psychiatrist, psychologist or group therapist.

- a. **Getting To Know You Games:** The large group is broken down into smaller groups. Each individual in the small group shares something about self with the group. After a few minutes the large group is reconvened, and the information discussed in the small group is shared in the larger group. Each person shares information about someone other than self. The process is repeated until information relative to biographical data, likes and dislikes and personal aspirations is shared. (verbal)
- b. **Life Lines:** Each person prepares a graphic representation of milestones in his/her life followed by discussion of each. (verbal and non-verbal)
- c. **Bomb-Shelter Exercise:** The process of being excluded from the group and experiencing feelings related to it. (verbal)
- d. **Picture Selection:** Give the participants a number of books and magazines to thumb through. Have each person select a picture that most represents them and tell the group about it. (verbal and non-verbal)

- e. Blind Man's Bluff: All participants are blindfolded and try to manipulate various aspects of their environment by focusing on the use of their other senses. (non-verbal)
- f. Trust Walk: The group is divided into pairs. One person in each pair is blindfolded. The pair takes a five minute walk; the person who is not blindfolded leads the person who is blindfolded. (verbal and non-verbal)
- g. Charades (non-verbal)
- h. Cooperation: Participants are to make five squares of equal size. This is limited to five participants. Each person is given three pieces of wood or paper of various shapes. Participants are to make squares by sharing but they cannot talk or ask questions; they can only give and receive. (non-verbal)

NOTE: All games and exercises must be followed by discussion of feelings and meanings obtained from them.

- 2. Group Discussions. Some group discussions can be led by the trainer as follow-up to the work done by the psychiatric or psychological consultant. Generally group discussions should be led by the psychiatric or psychological consultants. One of the purposes of the group discussion format is to clarify and reinforce information, feelings and/or conflicts. Role playing is an effective method by which the individual can help to understand self and others. The following are suggested role plays that could be used. In setting up role play situations the leader should ensure that each person is familiar with his/her own role only. If the various roles are known to all group members, spontaneity is lost. One of the functions of the role play process is to get honest, spontaneous reactions to simulated life experiences.
- a. Role Play

Purpose: To demonstrate the differences between negative and positive interactions.

Theme: Judy announces to the group that she is going to purchase a Cougar (car). At this point she is taking driving lessons but does not yet have her driver's license.

Situation a:

Judy: "I am going to get a Cougar."

First Respondent: "Shut up girl, you don't even have a driver's license."

Second Respondent: "You told me yesterday that you were going to quit, that your last lesson was awful."

Third Respondent: "You flunked the driver's test twice and you are going to get a car, ha, ha."

Judy: Facial expression shows hurt. She turns away from the group and says, I don't care what you say. I'm going to get my license and I'm going to get my Cougar. I'M GOING TO, I guess."

Leader stops the role play at this point and immediately has the group members act out situation (b). Do not discuss situation (a) at this point.

Situation b:

Judy: "I'm going to get a Cougar."

First Respondent: "Hey, that's great. Let me help you pick it out."

Judy: Yea, but I'm nervous. I don't even have my license.

Second Respondent: You know you are going to get it. Let's go out this afternoon and you can drive my car.

Judy: That will really help. My road test is two days from now and I am nervous.

Second Respondent: Okay, but you will pass. I know you will.

Leader stops the role play and leads a group discussion. The following are some questions that help to generate discussion:

1. To the person who played Judy: How did you feel in the first situation?
2. To the group: Did you consider the statements made in the first situation positive or negative?
3. How did you feel when you were making the statements in situation (a)?
4. Were they statements that you would have wanted made to you, if the roles were reversed?
5. In relation to situation (b): How did the person playing Judy feel this time?
6. Would you consider these statements more positive than the first set of statements? Why?

7. Can you think of real situations where you have had similar experiences? How did you react at that time? How did you feel?
8. Can you think of situations in which you could have been more supportive?

NOTE: It may be necessary for the trainer to use a personal example if the group shows signs of hesitating or unwillingness to share. Sometimes the sharing process is easier if the leader is willing to become a real part of the group—if the leader is also willing to share.

b. Role Play

Purpose: To demonstrate negative versus positive ways of interacting.

Situation a:

Alice walks into the room and begins gossiping about her supervisor.

Alice: "That....., I hate her. Had the nerve to tell me that I am not doing my job."

First Respondent: "Yea, she's always complaining. What did she tell you?"

Alice: "I'm on probation. The nerve of her, when I saw her with some man last night."

Second Respondent: "Yea, she has some nerve talking about us. She needs to get her life together."

Situation b:

Alice: "That....., I hate her. Had the nerve to tell me I'm not doing my job."

First Respondent: "You really sound angry Alice. Maybe after you calm down you need to talk with the supervisor."

Alice: "I have nothing to say to her. She's only picking on me because I saw her out last night."

Second Respondent: "Alice, you know that you have been late every-day this week. Now you have an attitude. I'm not going to listen to you. If you are that uptight you need to talk with the supervisor."

Alice: "Yea, you are right. I'm just mad. I'll talk to her."

3. Individual Sessions. The nature of this portion of the human relations dimension may require periodic individual meetings. These meetings should be conducted on an "as need" basis and led by the psychiatrist or psychologist. In any event, the trainer should conduct scheduled individual meetings with each trainee.

4. Didactic Lectures. These should be periodically planned should be conducted by outside consultants. These lectures should center around such related topics as Transactional Analysis, Freudian Psychoanalytic Theory, Gestalt Therapy and/or Supportive Techniques.

RESOURCES

Books:

- Berne, Eric. Games people play. New York: Grove Press, Inc., 1964.
- Brown, Calude. Manchild in the promised land. New York: The Macmillan Co., 1965.
- Collins, Vincent. Me, myself and you. Indiana: Abbey Press, 1969.
- Comer, James. Beyond black and white. New York: Quadrangle & The New York Times Book Co., 1972.
- Harris, Tom. I'm okay, you're okay. New York: Harper and Row, 1970.
- James, Muriel. Transactional analysis for mum's and dad's. California: Addison-Wesley Publishing Co., 1974.
- Jourad, Sidney. The transparent self. Princeton, N. J.: D. VanNostand Co., 1964.
- Powell, John. Why am I afraid to love. Illinois: Argus Communication, B - 106.
- Powell, John. Why am I afraid to tell you who I am? Illinois: Argus Communication, 3505 N. Ashland Ave., Chicago, Ill. 60657. B-119.
- Prather, Hugh. Notes to myself. Utah, Real People Press, 1970.
- Pietsch, William. Human be-ing. New York: Lawrence Hill and Co., 1974.
- Schiffman, Muriel. Self therapy. California: Self Therapy Press, 1967.
- James, Muriel and Jongeward, Dorothy, Born to win. Reading, Mass: Addison-Wesley Publishing Co., 1971.

2. Films:

Most of the following films are available through your local public

Library:

"Black, White and Uptight."

"Five on the Black Hand Side."

"The Autobiography of Miss Jane Pittman."

"Black History - Lost, Stolen or Strayed."
Bill Cosby, Narrator.

3. Videotapes:

"Child Development" - Ballard and Sparks, Property of Child Development Associates and Educational Television.

"Black Male - Black Female Relations" - Ballard and Walker, Property of Child Development Associates and Educational Television.

Both are available through the Child Development Associates, 7315 Wisconsin Avenue, Bethesda, Md.

4. Film Strips:

"Fuzzies"

"Feelings and Thoughts"

"Why Am I Afraid To Tell You Who I Am?"

All are available through the Argus Communications: 3505 N. Ashland Avenue, Chicago, Illinois. 60657.

ASSESSMENT

Written pre and post tests.

Observations.

Self-evaluations.

Written book, film and film strip reviews.

Completed discussion guides.

LEVEL B: COMMUNICATIONS

The ability to communicate openly and honestly is a necessary skill if one is to function as a capable, responsible adult. As a result, communication is an essential component of the human relations dimension of a training program. Communication relates to the process of effectively transmitting ideas and information from one source to another. The means used for communicating may be verbal, non-verbal, postural and/or gestural.

OBJECTIVES

1. Understand the meaning of the word communication.
2. Develop the ability to express feelings and thoughts accurately.
3. Develop the ability to communicate with others: how to talk, how not to talk to others.
4. Develop the ability to really listen and decode messages (active listening).
5. Develop the ability to be sensitive to other people's needs.
6. Become aware of messages sent by appearance and body language.
7. Develop the ability to give and take constructive criticism.
8. Develop the ability to cue in on and interpret the behaviors of others. (Read faces and body language).

METHODS OF COMMUNICATION

Communication exists on two broad levels - verbal and non-verbal. Within each of these levels there are sub-levels of communication.

1. Verbal communication essentially means using sounds to convey or transmit a message. Some sub-levels of verbal communication are:
 - a. Crying: Used by every human being, crying is the primary method by which infants communicate their needs.
 - b. Laughing
 - c. Yelling or screaming
 - d. Talking: The most frequently used form of verbal communication.

2. Non-verbal communication is commonly referred to as body language. It is communication which normally omits sounds. Some forms or levels of non-verbal communication are:
 - a. Gestures: Motoric behaviors that have significance: movements of hands, head, etc. when speaking or listening.
 - b. Signals: Sign language. Signals may sometimes be an intimate form of communication between two or more people. These may include winking of eyes, movement of hands or arms, upward movement of eyes, change of posture.
 - c. Symbols: These refer to the more external forms of communication such as traffic and road signs, traffic lights, medical symbols, etc.
 - d. Pictures: Self-explanatory pictures are most often used with children who have not yet acquired the skill of reading.

STAGES OF COMMUNICATION

There are four stages of communication that were considered important in the training program:

1. Delivering the message.
2. Attending to the message: Active listening.
 - a. Active listening is a process that involves not only hearing the words said by the other person, but also ~~cueing in~~ observing the non-verbal aspects of the communication and interpreting the words and actions. By cueing in we mean - staying with the message from start to finish, not cueing in on the beginning of the conversation and then automatically beginning to interpret. Interpretation begins when the verbiage has ended.

Active listening excludes judgement. Its' functions are: To show understanding and caring, to reduce threat, to build rapport and trust, and to open doors for further communication.
 - b. Prior to becoming an active listener, one must understand the various levels of listening.
 1. Parroting: Gives back word for word what was said.
 2. Interpreting: Translates content only into one's own words: Does not give feelings (emotion).
 3. Reflecting: How does one think the person felt; the emotion and asking for clarification; I think you felt.....Is that right?

- c. Active listening is a process. It cannot be taught in a one or two step fashion through didactic workshops. It has to be an integral part of the entire training process if it is to be internalized and become a natural part of an individual's daily interactions. An aspect of the role of the trainer is to create active listening situations during all facets of the training process. For example, during a discussion of the day's activities, the trainer stops the discussion and says, "Janice, can you tell me what Yvonne just said?" How do you think she felt when the particular incident happened? "Yvonne, is that what you said? Is that what you meant?"
3. Interpreting the message.
4. Accepting, internalizing and acting upon the message.

METHODS OF INSTRUCTION

1. Group Discussion. Group discussions can be varied by presenting topics for small group discussions. Working in groups of three, the students listen to the tape and do the required exercises in "Interpersonal Communications." Two students do the exercises; the third documents and evaluates the process.
2. Didactic Workshop Sessions. These can include lectures entitled: "What is Communication?", "Active Listening", and "Interpersonal Communication."
3. Games/Exercises. Many of the games and exercises included in Level A can be used here. Some others include:
 - A. Recognition: The group forms a circle. One person volunteers or is chosen to describe a member of the group. The person is given up to three minutes to recognize self.
 1. Discussion questions:
How did you know it was you?
Do you agree with the description?
What do you agree with most - least?
 2. Variations:
Describe positive traits only.
Describe negative traits only.
Limit description to physical characteristics.
Do not include any physical characteristics.
 - B. One Way Communication: Students work in pairs. Student A is given a picture. Student B is given pencil and paper. Student B must draw the picture but he/she cannot see the original picture. Student A must give student B verbal instructions without naming the picture. Student B cannot ask questions.

Variations: Two way communication. Same as above only this time Student B can ask questions.

- C. Paraphrasing: Leader or a group member makes a statement. Participants volunteer to paraphrase (say in own words).

Variations: Leader gives pre-selected passages from magazines or books. Participants paraphrase.

4. Role Plays. The following are a few examples of role plays that can be used to facilitate learning of the desired competencies for communication.

- A. You are the EPSDT nurse. You have been getting complaints from parents about one of the nurses aides. She has reportedly been rude to parents and verbally abusive of children. Most recently a parent complained that she yelled at a child who was afraid to be weighed. Talk this over with the nurses aide.

Nurses Aide: You believe in speaking your mind. You feel that you are being wrongly accused. Anyway, the children need to come to the doctor and comforting them does not work.

- B. You are a teacher's aide. You and a co-worker are supposed to work together with groups of children who have learning problems. You feel that your co-worker is not pulling his weight. He is always taking coffee and cigarette breaks and you have to work with the children alone. Handle this situation.

RESOURCES

1. Books:

Berne, Eric. Games people play. New York: Grove Press, Inc., 1964.

Berne, Eric. What do you say after you've said hello. New York: Grove Press, Inc., 1966.

Ginott, H. Between parent and child. New York: Macmillan Co., 1965.

Gordon, Thomas. Parent effectiveness training. New York: Peter H. Wyden, Inc., 1970.

Gordon, Thomas. Teacher effectiveness training. New York: Peter H. Wyden, Inc. 1972.

Katz, Robert. Empathy. New York: The Free Press of Glencoe, Macmillan Co., 1963.

Knoblock, P. & Goldstein, A. The lonely teacher. Boston: Allyn and Bacon Inc., 1971.

Rogers, Carl. On becoming a person. Boston: Houghton Mifflin Co., 1963.

3. Films:

"In The Eye Of The Beholder".

Same as Level A. (Available through your local public library).

4. Film Strips:

"The lalac Story," Argus Publications.

"Interpersonal Communications," Argus Publications.

(Available through Argus Publications: 3505 N. Ashland Ave., Chicago, Ill. 60657.

ASSESSMENT:

1. Have the student develop skits about transactional analyses. These skits are to be presented to the large group and interpreted and evaluated by the group - self and peer evaluations.
2. Reports on books, tapes, film strips and films. Reports should include interpretation.
3. Demonstrate insight into other's behavior by giving verbal reports. Trainer can verify by using perceptive checks. To evaluate accurately, the trainer must observe the same people.
4. Written pre and post-test data: These tests should be locally developed and based strictly on content.
5. Observations by trainer.

LEVEL C: OTHER EXTERNAL:

This level deals with those things that are external to the individual, i.e., a person, people, groups, systems. The purpose of this level is to help the individual identify and determine what makes the external forces function.

OBJECTIVES

1. Ability to share work responsibilities evenly.
2. Ability to cooperate on the job.
3. Ability to maintain discipline and control with children.
4. Ability to identify the power structure of the organization.
5. Ability to accept and appreciate cultural and ethnic diversity.

METHODS OF INSTRUCTION

1. **Group Discussion.** This should be an extension of Level B. While working on Level B students should schedule several sessions with an individual outside the project staff to complete the tape and exercise sessions in "Effective Communication."

Group discussions should also center around content areas included in didactic workshop sessions. This serves as a means of reinforcing what is learned.

2. **Didactic Workshops.** Some of the lecture topics for Level C should include:

How to deal with parents.

How to deal with children.

Working in groups.

Humanistic Instruction

Encouraging children

What is an organization.

Job Skills

Responsibility

Motivation

3. **Role Plays.** The role play examples included in Level A and B are also relevant here.
4. **Games/Exercises/Ice-Breakers.** The examples given in Level A and B can be used here. Another example is:

The Boat Ride: The boat ride is planned. Everyone can go but in order to go everyone has to bring something. The leader goes around the group asking each person what they would like to bring. People can only be included on the boat ride if their contribution begins with the first initial of their first or last name. The leader knows the rules of the game, but the participants have to guess.

RESOURCES

1. Books:

Bonner, Hubert, On being mindful of man. Boston: Houghton Mifflin Co., 1965.

Combs, Arthur, (ed). Perceiving, behaving, becoming. Washington, D.C.: Association for Supervision and Curriculum Development, National Institute of Education, 1962.

Dinkmeyer, Don, Group counseling theory and techniques. The School Counselor, 17, 1969.

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2. Cassette Tapes:

Same as Level B.

3. Films:

"In the Eyes of the Beholder." (Available through your local public library).

4. Handouts:

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ASSESSMENT

Identification of the power structure of his or her own organization in written and graphic form.

Books reviews with interpretations.

Review of film "In the Eye of the Beholder."

Pre and post test.

Post test for entire Human Relations dimension.

CHAPTER THREE
MEDICAL

PRIMARY SOURCE:

BETTER HOMES & GARDENS
FAMILY MEDICAL GUIDE
REVISED EDITION
Ninth Printing, 1977
MEREDITH CORPORATION

WITH INPUT FROM:

Catherine Gillis, R.N.
Susan Woolsey, R. N., P. N. P.

CHAPTER III

MEDICAL

INTRODUCTION

Included in this section is content for an introductory "mini-course" in nursing. The overall aim is to provide the students with knowledge and skills that would enable them to function as a nurses aide. The course does not, either by design or intent, train the student to replace the professional nurse. Rather, once trained the student can serve as a supplement to the nurse.

PURPOSE

The specific purpose of the medical training is to train paraprofessionals to competently perform specific tasks in the areas of medical screening, record keeping, outreach and follow up.

PERFORMANCE/OUTCOME OBJECTIVES

To train paraprofessionals to perform tasks in the above mentioned areas learning has to take place in three different yet interrelated domains: the psychomotor domain, the cognitive domain and the affective domain. The following are the outcome objectives for each of these domains.

1. Psychomotor Domain

A. Demonstrate accuracy of findings and correct techniques in carrying out the following:

1. Measuring the height of a child.
2. Measuring the weight of a child.
3. Measuring the temperature of a child.
4. Counting the respiration of a child.
5. Counting the pulse of a child.
6. Taking the blood pressure of a child.
7. Collecting a clean catch urine specimen.
8. Recording on child's chart the above findings.
9. Assisting in hearing screening.
10. Showing competency in using the audiometer and impedance meter.
11. Assisting in vision screening.
12. Showing familiarity with the "E" chart and snelling chart.
13. Supportively preparing the child for the events and feelings of a physical examination.
14. Talking with caretakers about child's health/illness.
15. Completing parental consent forms.

B. Apply, in work with children, the principles of growth and development to establish a helpful and respectful relationship with the child.

C. Apply principles of first aid to a simulated emergency setting with a child.

II. Affective Domain

A. Appreciate the uniqueness of all individuals.

B. Demonstrate an awareness of children's need to be cared for, supported, and treated respectfully.

C. Appreciate the numerous difficulties facing parents in caring for their families.

III. Cognitive Domain

A. Identify the general physical health needs of children at different ages.

B. Apply principles of growth and development when problem solving about the care of children.

C. Identify the purpose of screening children for medical problems.

D. Specify the purpose of measuring:
Temperature, pulse and respiration
Blood pressure
Height and weight

- E. Distinguish the well child from the sick child.
- F. Identify common reasons for illness in children and how they may be prevented.
- G. Identify the major systems of the body.
- H. Specify the general functions of each system.
- I. Define terms commonly used in the medical screening of children.

The following is the medical course content presented in modular format.

MODULE ONE: PREPARING THE CHILD FOR SCREENING/PHYSICAL EXAMINATIONS

OBJECTIVE

The trainee will be able to prepare a child for a physical screening examination.

SECONDARY OBJECTIVES

1. Define values.
2. Define attitudes.
3. Specify the components of attitude.
4. Appreciate the child's need for honesty and caring.
5. Recognize a child's realistic fear of being examined.
6. Identify behaviors that indicate that children are frightened.
7. Recognize that all people are more similar than different.

A. CONTENT/DISCUSSION

A physical examination is a regular part of the EPSDT screening process. Most children are afraid of what will happen when the doctor uses all those "odd things," takes them in a room and shuts the door. If a child is crying and tense, or fights, the doctor will not be able to do what is necessary to see that he/she is healthy. A good health assistant finds ways to explain what the doctor will do so that children will cooperate.

B. WHAT YOU NEED TO KNOW

1. The doctor will look, listen and feel. He may or may not give a shot depending on the situation. Often in clinic, technicians draw blood and nurses give immunizations.
2. It should not be necessary to remove all the child's clothing at once. If he/she can, let him/her remove and put on his/her own clothes. This will help the child feel that he has some control over what is happening to him/her. It also makes him/her feel "big."
3. If time permits, name each piece of equipment and tell the child what it is used for. This helps him/her not to be afraid of what the equipment MIGHT be used for. Fear of the unknown is very hard for children (and adults) to handle. It would help to let the child handle some of the equipment and try them out.
4. If you have developed rapport with the child, stay close by and touch him/her.

C. WHAT THE DOCTOR NEEDS

1. Otoloscope -ophthalmoscope - This is the instrument used for examining eyes and ears.
2. Ear speculum - This is attached to the otoscope and goes into the ear. A clean one is used for each child.
3. Cotton balls and alcohol for washing ear specula.
4. Flashlight and tongue blades for examining the throat.
5. Stethoscope - for listening to the chest.
6. Sphygmomanometer - for determining the blood pressure.
7. Percussion hammer - to determine deep tendon reflexes.
8. Large rolls of paper - for the examining table. These should be pulled and discarded after each child is examined.
9. The child's health record with height, weight, immunization record, temperature, pulse and respiration, vision and hearing screening, recorded on it.

D. WHAT YOU NEED TO DO/WHAT TO TELL THE CHILD

1. Be sure that all necessary equipment is ready for the doctor. It will help if you watch the doctor do one physical examination before you assist with one.

2. Explain what will happen to the parent and child.
3. The doctor will usually examine the child's head with him/her standing. He may even do the chest exam with him/her standing. The child's shirt should be taken off for the chest examination. You may need to help with this. Doctors have different methods of examining. You will need to take your cues from him. Usually he/she will proceed from head to chest, to abdomen (tummy or belly). After the examination of the abdomen, the doctor will proceed to examine the genitals. For the genitalia, the pants will need to be pulled down. This will need to be explained to the child. Simple words like, "The doctor is just going to look," will reassure the child.
4. Stay beside the child when he/she is on the table. This is a safety precaution. Hold the child if the doctor requests that you do so.
5. Be honest - tell the child what will happen. If he/she is going to get a shot, or have blood drawn, tell him/her that it is going to hurt. The hurt won't last but it will hurt.
6. Tell the child that it is okay to be scared and it is okay to cry. Even adults get scared sometimes.
7. Tell the children that the doctor is going to check them to make sure they are okay. He/she does not want to scare or hurt them.

MODULE TWO: GROWTH AND DEVELOPMENT IN CHILDREN

OBJECTIVE

The trainee will apply the principles of growth and development in interacting with children of different ages.

SECONDARY OBJECTIVES

1. Identify the normal parameters of height, weight, temperature, pulse and respiration in children of different ages.
2. Identify those elements which are essential to the growth and development of children.
3. Identify examples of those essential elements.
4. Differentiate normal findings from abnormal when examining parameters in children.

CONTENT/DISCUSSION

A. INTRODUCTION TO GROWTH

Growth is the increase in size and number of the cells that make up the body. When babies are born they may weigh seven pounds. They grow very fast and by four or five months of age they will have doubled their birth weight. At one year old most babies will weigh three times their birth weight, around twenty to twenty-one pounds. By the time they are two years old they will weigh twenty-five to twenty-six pounds. During the next pre-school years they will gain about four pounds a year. By the time they are grown, they will be twenty times their birth weight.

The same rapid development is also true for children's heights. Most babies are between nineteen to twenty-one inches tall at birth. They will grow about ten more inches by the time they are a year old and another five inches by the time that they reach the age of two. This means that by the time children are two-and-a-half years old, they are half as tall as they will be when they are fully grown - usually eighteen to twenty-one years old. Until they are ten years old they will grow two-and-a-half to three inches a year. For two or three years following the tenth year children will not grow much until they reach adolescence. At that point there is, once again, rapid growth. This is referred to as the adolescent "growth spurt."

An important thing to know about growth is that each child is an individual and very few growth patterns will be exactly the same. Genetics are pre-determining factors - the size of the parents affect the size of the child. Short parents will probably have short children and tall parents will have tall children. Of course, there are variations within families. Children set their own patterns. The adults responsible for children should see that they have enough of the

right foods, enough chances to play and exercise, enough sleep, and regular medical check-ups. Children should be held, talked to, cuddled and loved. Scientists have proved that all of these things are absolutely necessary if children are grow well.

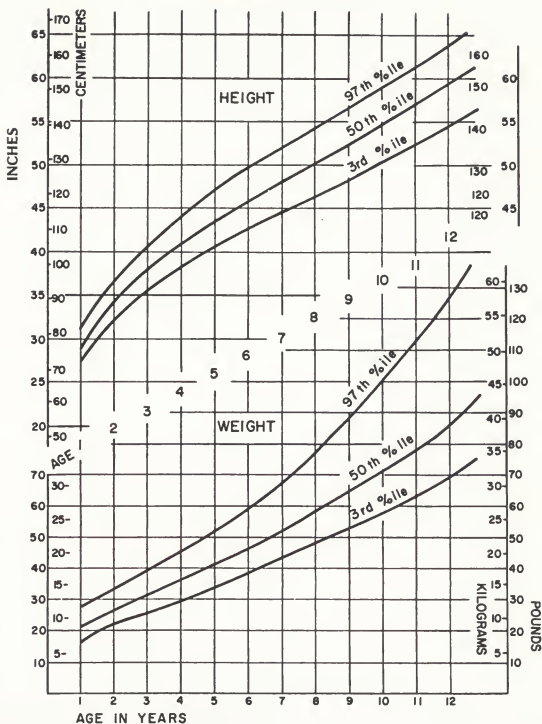
How do we know if children are growing well? We have to check them on a regular schedule and keep absolutely accurate records. Doctors say we should take babies to be checked at the following ages: One month, two months, four months, six months, twelve months, eighteen months, two years, two-and-a-half years, three years and every year after that. Since we know how fast children grow, we can see why it is important to check them quite often. If growth slows down the doctor can determine the reasons as early as possible and help correct (treat) the cause.

Learning to use a growth chart: This takes some practice, but the information from a growth chart is very important to help you see if children are growing normally. We have already talked about each child having his/her own individual pattern. The growth chart is really a picture of that pattern.

Look at the growth chart (next page). On the bottom of that chart you see the numbers one through twelve. These represent the ages of the child. These numbers also go at an angle through the middle of the chart. This helps you when you record the child's height and weight.

Look at the chart again. In the top section you see the word "HEIGHT." Record the child's height in that section. On the outside on both sides of the chart you find numbers representing inches. In the bottom section you see the word "WEIGHT." Record the weight in that section. On the outside on both sides you find numbers. Take a pencil and practice plotting some heights and weights.

GROWTH CHART



I give my permission for _____ to have all necessary medical examinations, immunizations, laboratory tests, and treatments from the physicians, dentists, and other health personnel of the pre-school and school health programs

Date

Signature of parent or guardian

B. INTRODUCTION TO DEVELOPMENT

DEVELOPMENT is related to movement toward maturity; we are developing all the time, but just as growth is VERY RAPID in the very young, so is development VERY RAPID in the first few months of life. There are many kinds of development: Personal-Social, Motor- (small and large muscle), Emotional or Affective and Intellectual or Cognitive.

Many aspects of various developmental systems are covered in appropriate sections of this manual. The following pages cite specific developmental tasks that the physician may be interested in at the time of the physical examination.

TWO TO THREE YEARS OLD

Personal Social

Is toilet trained.
Partakes in parallel play.
Removes one piece of clothing.
Feeds self with spoon.
Removes shoes.
Holds small glass with one hand.

Motor -

Climbs one step at a time.
Can squat and balance.
Runs without too many falls.
Kicks medium sized ball.
Throws small ball underhand.
Jumps over small objects.
Walks on toes after demonstration.
Raises one hand over head.

THREE TO FOUR YEARS OLD

Personal Social -

Unbuttons "easy" buttons.
Puts on shoes and socks.
Uses fork.
Wipes up spilled liquids.
Plays cooperatively.
Brushes teeth.
Helps with minor household tasks.
Buttons large buttons.
Shares when asked.
Serves self at meal time.

Motor -

Walks backward.
Hops.
Imitates heel to toe.
Broad jumps twelve inches.
Gallops.

FOUR TO FIVE YEARS OLD

Personal Social -

Tells front from back of clothes.
Plays with a group.
Has special friends.
Washes face and hands.
Puts toys and belongings away.
Goes to bathroom alone.
Zips with little assistance.
Laces shoes.
Engages in imaginative play.
Seeks adult recognition and praise -
"Look what I did."
Is cautious about common dangers.

Motor -

Throws small ball overhead.
Skips.
Handles Fragile objects.
Places one hand on shoulder, other on hip.
Touches toes.
Climbs steps like an adult.
Stands on one foot with one hand on elbow.

FIVE TO SIX YEARS OLD

Personal Social -

Ties own shoes.
Uses knife with partial success.
Plays competitively.
Accepts adult supervision.
Tries to obey rules.
Dresses and undresses self.
Total bathroom self-care.

Motor -

Jumps rope.
Touches nose with finger.
Bounces large ball several times.
Imitates frog jump.

This section covers some of the general developmental competencies that the doctor looks for when examining the child, and/or questions that the parent is expected to answer. Children at different ages are expected to perform these tasks with varying degrees of competence.

Intellectual -

Solves problem for self.
Finishes work.
Is independent in thinking and acting.
Has ability to choose and decide.
Is interested in things going on.
Responds to suggestions.
Shows imagination.
Has good memory.
Has good reasoning.
Can follow directions.
Asks many questions.
Answers questions appropriately.
Feels free to speak.
Speaks rarely.

FIVE TO SIX YEARS OLD

Intellectual (continued).

Has speech defects.
Is easy to understand.
Listens to others.
Identifies sounds.
Has vocabulary relative to age.

Physical -

Small muscle movement

Hand-eye coordination:
Carries and places objects
Handedness. Uses scissors, tools,
blocks, crayons.

Large muscle movement

Hops, skips, jumps, runs, balances.

Social -

Responds to environment.
Participates in creative art activities.
Initiates activities.
Needs encouragement to participate.
Describes things verbally.

Enjoys participation in activities.
Is willing to use "messy" materials -
clay, paint.
Tries out new material and colors.
Enjoys stories - listens, understands,
remembers.
Enjoys music - listens, sings, dances,
uses instruments.

Emotional -

Is able to share.
Is neat.
Is shy.
Relates to others - adults, children and
objects.
Plays alone with others.
Cries when left by familiar adults.
Is overly sleepy.
Is passive - stays alone, won't stand up
for self.
Is aggressive - hits, pulls, pushes,
bites.
Day Dreams.
Has ability to concentrate.
Blames self or others.
Accepts limits.
Tests limits.

C. WHAT YOU NEED

1. A balance scale with measuring device or a balance scale, measuring tape and ruler.
2. Paper towel.
3. Paper, pen or pencil.
4. The child's medical record.

D. WHAT YOU NEED TO KNOW

1. Weight should be taken on the same scale each time if possible.
2. The scale should be balanced after a paper towel is put on.
3. The child should be weighed at the same time each day if possible.
4. Shoes and all heavy clothing should be removed.
5. The child's last weight should be checked before you start. If the child is four years old now and weighed thirty pounds when he/she was three, you would expect the child to weigh about thirty-five pounds now. If the child still weighs thirty pounds, weigh the child again to double check. If thirty pounds is accurate you should bring it to the attention of the doctor.

E. WHAT YOU NEED TO DO/WHAT TO TELL THE CHILD

1. Have the scale standing level on the floor.
2. Place paper towel on scale.
3. Balance scale.
4. Explain what you are doing to the child. If a parent is with the child this will help. You should show the parent the child's record and his/her growth pattern. This will help reinforce for the parent that the child's growth is important.
5. Have the child remove heavy clothing and shoes. Help him/her if necessary. (Be sure there is a chair for the child's belongings near the scale so that he/she can see them at all times).
6. Tell the child to step on the scale and stand very still. You should stay in his/her line of vision at all times.
7. Arrange the weight indicator to the point where it is balanced. Say out loud the number of pounds and write down immediately. This is important since it is so easy to forget; also you can determine if you need to check it again. In addition, the child will be happy to know his/her own weight.

8. Have the child step off the scale and put his/her clothes on. He may need some help from his/her parent, or from you, but have him/her do all he can by himself.
9. If the scale has a measuring device, have the child turn around, putting his/her back and heels to the wall.
10. Put the ruler straight across the top of the child's head to determine the height. If the child's hair is thick, be sure the ruler is on the child's head not on top of a high hairdo.
11. Call out the number of inches, and write it down immediately. Check to see if he/she is about as tall as you would expect. If not, be sure to measure him/her again. Both the child and parent will want to know if the child "is getting to be a big boy or girl."
12. Plot the height and weight on the Growth Chart.
13. Throw the paper towel away and move the indicator back to balance the empty scale.

MODULE THREE: ANATOMY AND PHYSIOLOGY OF MAN

MODULE FOUR: VITAL SIGNS AND LABORATORY WORK RELATED TO BODY

OBJECTIVE

The trainee is able to describe major body systems and their functions, to promote their understanding of the examination of the child and the rationale for vital signs and specimen collection.

SECONDARY OBJECTIVES

1. Name the seven major body systems.
2. Specify the major function of each system.
3. Relate temperature, pulse and respiration to their respective body system.
4. Identify possible problems that can be detected through examination of blood and urine.
5. Describe the method and purpose of clean catch urine collection.
6. Describe the method and purpose of holding a child for blood examination (withdrawal).

A. Content for Major Body Systems

The body is composed of cells, which make up tissues, which make up organs, which make up systems. There are seven major body systems.

1. CARDIAC SYSTEM

a. Parts or organs. Heart, veins and arteries.

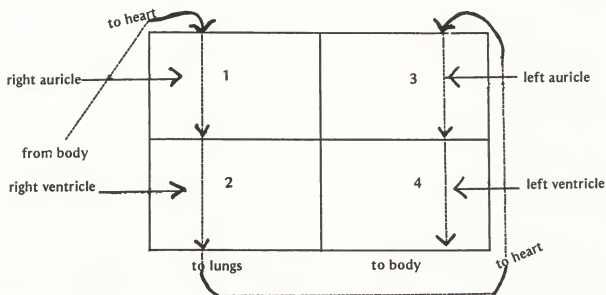
b. Purpose:

To pump blood that nourishes the tissues with food and oxygen and removes wastes from those tissues.

c. How it works:

The heart has four compartments or CHAMBERS. Blood flows from the top right chamber, called the right AURICLE, to the BOTTOM right chamber, called the right VENTRICLE, and out to the lungs to the top left chamber, called the left AURICLE, and leaves the heart from the bottom left chamber, called the left VENTRICLE. The flow of blood looks like this:

DIAGRAM OF HOW BLOOD FLOWS INTO THE HEART



- d. A pulse can be felt in **ARTERIES**, not veins.
- e. There are four blood types: O, A, B, Ab. There are two blood factors: Positive and negative.
- f. Bad Signs:
 - 1. Pulse irregularities: Too fast, too slow and misses beats.
 - 2. Extra heart sounds or **MURMURS**.
 - 3. **CYANOSIS**: A bluish or purplish discoloration due to deficient oxygenation of the blood. Usually shows on the lips and/or finger tips.
 - 4. Clubbed fingers.
 - 5. Abnormal blood studies.

2. RESPIRATORY SYSTEM

Your respiratory system includes all the parts of your body directly involved with bringing fresh air and oxygen into your body and getting rid of the body's waste products (carbon dioxide) through the air. This means everything from your nose and throat all the way down to your lungs.

- a. Parts or Organs:
 - 1. Lungs: The basic respiratory organ of air-breathing vertebrates.
 - 2. Bronchi: Branches of the bronchial tubes - located in the lungs.
 - 3. Nose
 - 4. Mouth
 - 5. Diaphragm: A partition of muscle and connective tissue located at the base of the lungs. It moves so that the lungs can expand or exhale and inhale.
 - 6. Larynx: The modified upper part of the trachea that forms the vocal cords.
 - 7. Trachea or windpipe: The main trunk of the system of tubes by which air passes to and from the lungs.

8. Pharynx: Throat.

b. Purposes:

1. Gets oxygen for blood.
2. Gives off carbon dioxide.
3. Warms and cleans air entering the body.

c. Bad Signs:

1. Gasping: Difficult or hard breathing, panting.
2. Pain.
3. Cyanosis (see Cardiac System).
4. Asymmetry: Lack of proportion.
5. Coughing - sore throat.
6. Wheezing: Breathing with difficulty - makes rasping sounds when breathing.
7. Squatting to breath.

d. Notes:

It is important to look upon your nose, mouth, and lungs as belonging to a whole system. This is an excellent preventive medicine orientation.....to think in terms of healing your cold or sore throat before the infection spreads to your bronchial tubes and lungs.

3. DIGESTIVE SYSTEM

This is the system of the body that is responsible for making food absorbable by dissolving it and breaking it down into simpler chemical compounds. This process occurs through the action of enzymes secreted into the alimentary canal.

DIGESTION is a process of continuous chemical simplification of materials that enter the body via the mouth. Materials are split into smaller and simpler chemical fragments which can then be absorbed through the walls of the digestive tract and finally enter the body.

A. Parts or Organs:

1. Mouth, teeth, tongue: Digestion begins in the mouth with grinding of food by the teeth and mixing it with saliva and enzymes.
2. Esophagus: A muscular tube. Here constriction and relaxation of the muscles propels food and other substances through the tube into the stomach.
3. Stomach: The biggest bulge in the digestive tract. It is located behind the lower ribs. It is a flexible bag enclosed by muscles. Here the food is mixed with enzymes and made more liquid.
4. Liver: Largest solid organ of the body. It occupies the upper part of the abdomen beneath the diaphragm. The liver manufactures enzymes and bile which aid in digestion.
5. Gall bladder: A saclike storage organ. It holds bile, modifies it chemically, and concentrates it. At appropriate times it squeezes concentrated alkaline bile into the duodenum.
6. Small intestine: A tube made up of several parts. Digestion is completed in the small intestine where all absorption of nutrients occur. The parts of the small intestine are:
 - a. Duodenum: Juices from the liver and pancreas are secreted into the duodenum.
 - b. Jejunum which joins the duodenum.
 - c. Ileum constitutes the rest of the small intestine.
7. Large intestine is a storage, dehydration and elimination organ joined to the small intestine: The parts of the large intestine are:
 - a. Cecum: Located just below the function at which the small and large intestines join. The appendix dangles off the cecum.
 - b. Colon: Which is divided into the ascending colon, transverse colon and descending colon.
 - c. Rectum.
 - d. Anus.
8. Pancreas: Looks like grapes on a stalk. It has a double purpose:
 - a. It secretes insulin into the blood.
 - b. It's juice contains enzymes that split fat, protein and carbohydrates. This juice is collected into the pancreatic duct which joins with the bile duct.

B. Purposes:

1. To obtain and process foods for the body.
2. To eliminate solid waste matter from the body.

C. Bad Signs:

1. Refusal to eat.
2. Nausea.
3. Vomiting
4. Diarrhea
5. Constipation
6. Pain
7. Blood in stools.

4. GENITO-URINARY TRACT

a. Parts or Organs:

1. Kidneys: A bean shaped organ weighing about one-half pound. We have two kidneys located behind the abdominal cavity. The kidneys form urine, filter many materials from the blood, return materials to the body to maintain proper concentration of electrolytes and fluids.
2. Ureters: Tubes, leading from the kidneys into the bladder, which carry urine into the bladder.
3. Urethra: External openings through which urine is disposed.
4. Bladder: A storage chamber from which, at convenient times, accumulations of urine are disposed of via the urethra.
5. Reproductive organs - females:
 - a. Ovaries: There are two ovaries. They have two functions:
 1. To produce ova or egg cells.
 2. To secrete hormones - estrogen and progesterone.
 - b. Fallopian tubes (oviducts) carry ripened ova (eggs) to the cavity of the uterus. The oviduct is usually the site where fertilization takes place.

- c. Uterus: (Womb). It is a pear-shaped, muscular, hollow, nesting place for the fetus in pregnancy.
 - d. Cervix: The tapering neck of the uterus.
 - e. Vagina: A muscular canal lined with mucous membranes which opens at the surface of the body and extends inward to the cervix. It is the female organ of copulation (sexual intercourse).
6. Reproductive organs - males:
- a. Prostate gland: Accessory sex glands of the male and structures associated with the urinary tract. It develops under the influence of male hormones. Ducts which carry sperm from the testicles enter the prostate.
 - b. Testis (testicle): Primary male sex glands or gonads. They are paired organs enclosed in the pouch of the scrotum.
 - c. Penis: The external male sex organ.
 - d. Scrotum: The pouch covering the testicles.

B. Purposes:

- 1. Removal of liquid waste.
- 2. Sexual reproduction

C. Bad Signs:

- 1. Not urinating
- 2. Thick discharges from penis or vagina
- 3. Pain when urinating.

V. NERVOUS SYSTEM

Without a nervous system, man would be doomed to a senseless, motionless, thoughtless, vegetative existence.

A. Parts or Organs:

- 1. The brain: Located within the head, the human brain contains upwards of twelve billion nerve cells, each of which is linked to others. The brain is composed of several parts:
 - a. The cerebrum which is made up of everything that lies above the level of the eyes.

- b. Cortex: A grayish layer of nerve cells, beneath which is white tissue, which is concerned with the conducting of impulses along fibres.
 - c. Basal ganglion which is gray matter at the base of the white tissue. The grey matter is concerned with distribution of impulses.
2. Spinal column or cord: A soft, fluted column of nerve tissue continuous with the lower part of the brain and enclosed in the bony vertebral column. Except for the twelve pairs of cranial nerves which connect directly with the brain, all the nerves of the body enter or leave the spinal cord through openings in the vertebrae.
3. Nerves:
- a. Cranial nerves: There are twelve pairs of cranial nerves which arise in the lower part of the brain and branch out to the muscles of the face and eyeball providing pathways for sensations of hearing, smell, taste and vision. One cranial nerve extends down the neck into the abdomen and chest and is concerned with regulation of breathing, rate of heartbeat, and the motility and gland secretion of the digestive tract.
 - b. Peripheral nerves: There are thirty-one pairs of peripheral or spinal nerves. These nerves, at different levels of the spinal cord, regulate activities of different parts of the body.
- B. Purposes:
- 1. Communication within the body.
 - 2. Communication between the body and the environment.
- C. Bad Signs:
- 1. Spastic movements
 - 2. Delayed or immature development
 - 3. Inability to communicate
 - 4. Seizures
 - 5. Failure to learn to read and write
 - 6. Strokes

- D. Important Points: All that you know, sense, experience and remember about the world about you is conveyed to you by the body cells that specialize in communication. These cells mediate messages that move muscles, give meaning to the printed page, regulate hundreds of automatic activities, e.g. heartbeat. These cells with their associated structure make up the nervous system.

VI. SKELETAL SYSTEM

A. Parts or Organs:

1. **Bones:** There are seventeen different types of bones in the body. Perhaps one of the most important are the bones that make up the spinal cord—the vertebrae. Besides providing support for the body, the bones produce red blood cells continuously. They also furnish levers for the muscles to pull upon so that our movements are not blob-like.
2. **Teeth:** There are normally thirty-two permanent teeth in the body. Each tooth has a crown and a root. The crown is the part that is visible when the mouth is open. The root is usually two or three times longer than the crown and it fits into a bony socket in the jaw. The main function of teeth is to prepare food for good digestion.
3. **Tendons:** Bands of tough, white fibrous tissue that connects muscles to bones.
4. **Ligaments:** Bands of tough, flexible fibrous tissue when connect bones or support organs.
5. **Joints:** Structures that permit one bone to glide over another and permit different ranges of movement.
6. **Cartilage or gristle:** White, elastic, connective tissue. Cartilages cushion the opposing surfaces of joints.

B. Purposes:

1. Protects other organs.
2. Makes red blood cells: Hemopoiesis

3. Supports the body.
4. Ensures mobility (movement) of the body.
5. Prepares food for digestion (chews food).

C. Bad Signs:

1. Delayed growth
2. Broken Bones
3. Decaying teeth
4. Pain

VII. MUSCULAR SYSTEM

A. Parts:

1. Muscles: There are sixty-seven muscles in the body. Muscles move body parts by contracting, and often pull against bones that serve as levers.
2. Tendons: Fibrous cords at the termination of a muscle that attaches it to a bone.

B. Purposes:

1. Mobility
2. Posture
3. Heat Production

C. Bad Signs:

1. Ptosis: Droopy eyelids
2. Fatigue: Inability to use muscles
3. Spasms (spastic movements): Sudden, severe, involuntary contraction of muscles interfering with function and often causing pain.
4. Delayed fine or gross motor development.

VIII. ENDOCRINE SYSTEM

A chemical system of communication between cells. It collaborates with the nervous system in adjusting the body to constant internal and external buffetings of the environment.

A. Parts:

1. The endocrine (ductless) glands. These glands are the same for men and women, except for the gonads - the testes and ovaries of the respective sexes. They are listed as follows:
 - a. Pituitary gland (the master gland): Located in the very center of the head, secretes hormones which regulate the rate of secretions of other glands. It secretes a substance which plays a role in the production of milk. It secretes "growth" hormones for growth and regeneration. It regulates water balance and the contraction of muscles and blood vessels during childbirth.

- b. Thyroid glands secrete a protein substance containing iodine. They regulate the rate at which body cells use oxygen. This is called metabolism.
 - c. Parathyroid glands are located within the thyroid glands. They regulate the amount of calcium in the blood.
 - d. Adrenal glands secrete adrenalin which regulates metabolic processes in cells. Hundreds of compounds are produced here to regulate the storage of sugar in the liver, skin coloration and sex hormones. A portion of the adrenal glands produces epinephrine which regulates dilation of eyes, blood pressure, sugar in the blood and goose bumps.
 - e. Stomach and duodenum produce gastrin which helps in the digestion of food.
 - f. Pancreas: Little islands of tissue in the pancreas secrete insulin which regulates the amount of sugar in the blood.
 - g. Ovaries or testes determine sex characteristics, body hair distribution, voice differences, amount of fat unnder the skin, sex drive, mental vigor and blood circulation.
- B. Purposes:
- 1. Communication within the body.
 - 2. Control and integration of body (growth, muscle contraction, labor, lactation).
- C. Bad Signs:
- 1. Growth abnormalities: Dwarfism, extreme shortness, giantism, extreme tallness, acromegaly, elongated fingers, fat jaw, or head changes.
 - 2. Diabetes
 - 3. Hyperactivity
 - 4. Sterility

B. TAKING THE VITAL SIGNS: TEMPERATURE, PULSE, RESPIRATION—(TPR)

I. THE TEMPERATURE

a. BODY TEMPERATURE:

Just as the oven or refrigerator have thermostats, the body also has a "thermostat." Of course, it is very complicated. Scientists tell us that the body temperature is controlled through the blood. When it reaches the brain and spinal cord, signals are sent to the metabolic processes that produce heat. The body loses heat when we breathe, perspire, regurgitate (vomit), urinate or defecate. When a person is well, a balance is maintained between heat production and heat loss. When a person is ill, often the balance between heat production and heat loss is upset; body temperature either rises above normal or falls below normal. There are some other things that can cause the temperature to be high - for example, if one has been outside in the sun on a hot day.

b. TAKING THE TEMPERATURE:

The thermometer is placed in the mouth to take the temperature orally, in the anal canal (rectum) to take the temperature rectally, or in the axilla (underarm) to take an axillary temperature. The rectal temperature is the most accurate and axillary least accurate. The average oral temperature is 98.6° , a temperature as low as 97.6° or as high as 99.6° is not considered abnormal. Just as children's growth and development vary, so do other physical aspects vary from child to child. In other words, there is a normal range.

c. WHAT IS A FEVER:

When the oral temperature is over 100° or the rectal temperature is over 101° this is considered to be a fever. Fever is one of the body's responses to illness. A child who has a fever usually also has a headache,

doesn't want to eat, is whiney, sick-looking, sleeps more, may have glassy looking eyes, does not urinate, has dry lips, and breathes faster than normal.

d. WHAT IS A THERMOMETER:

The thermometer has two parts: The bulb and the stem. Mercury is in the bulb and will expand and rise in the stem when it is heated. The stem is marked in degrees and tenths of a degree. Fractions of a degree are recorded in even numbers, that is .2, .4, .6, or .8. Thermometers have either slender long bulbs or blunt short bulbs. The ones with slender long bulbs are for taking oral or axillary temperatures. The blunt short bulb is for taking rectal temperatures.

e. WHAT YOU NEED:

1. Thermometer
2. Lubricant (rectal temperature)
3. Disinfectant (soap, alcohol, zephiran)
4. Cotton balls or soft tissue
5. Watch with second hand
6. Paper and pencil or pen
7. Child's record

f. WHAT YOU NEED TO KNOW:

1. Never take an oral temperature of an unconscious or uncooperative child, or a very young child.
2. Do not take an oral temperature if the child has had a warm or cold drink beforehand.
3. Never wash a thermometer with hot water.
4. Be sure you shake the mercury to below 95° - grasp it firmly with thumb and forefinger and with a strong wrist and forearm movement shake it hard.

g. WHAT YOU NEED TO DO/WHAT TO TELL THE CHILD:

1. For oral temperature:

- a. Shake thermometer down.
- b. Read it to be sure it is below 95°
- c. Rinse with cool water.
- d. Tell the child about the procedure.
- e. Place the bulb end under the tongue and caution child NOT to bite and to keep his/her mouth closed. (The child may want to put the thermometer into his/her mouth himself.)
- f. Leave thermometer in for at least five minutes.
- g. Remove the thermometer. Check it to be sure the temperature has registered and is within normal range. If not, either place it in the mouth, or start procedure again with another thermometer, to ensure that your reading is accurate.
- h. Clean the thermometer by using soap and water, zephiran, or some other disinfectant. Wipe from the fingers down toward the bulb with a firm twisting motion.
- i. Hold thermometer level in front of eyes and turn until you see the level of the mercury clearly.
- j. Say temperature out loud and tell the child and/or parent what it is. This is a chance to do some teaching. You can tell them what is normal, and whether the child's temperature is in the normal range, and that taking the temperature is one way to find out if he/she is well.
- k. Write the temperature down.

2. For rectal temperature:

- a. Shake the thermometer down as for oral temperature.
- b. Lubricate with white vaseline or commercially prepared lubricant.
- c. The child will probably be quite frightened by this procedure since he/she can't see where you are putting the thermometer and he/she may think you will give them a shot. If a parent or someone that he/she knows is with him/her, it may help to let that person take the temperature. It is easiest to place child on abdomen over the knees of the sitting adult.
- e. Hold thermometer in place the entire time - two to three minutes. NEVER leave a child who has a thermometer in place.

- f. Wipe with dry tissue or cotton ball, from the finger to the bulb, with a twisting motion.
- g. Clean with soap or disinfectant as for the oral thermometer.
- h. The thermometer should be placed in a special container to be disinfected.
- g. Read and record.

NOTE: Many places have disposable covers for thermometers now. If these are available, you will use a different procedure.

3. For axillary temperature:

- a. Read and shake down thermometer.
- b. Hold child on lap or have parent hold him/her. Explain the procedure and tell the child that he/she will have to be still for a long time.
- c. Place the thermometer well in the axilla (armpit) with bulb directed toward the child's head. Bring his arm down close to his body and place his forearm over his chest. Don't leave a child alone during this procedure. The thermometer must stay in place for at least ten minutes.
- d. Remove, clean, read and record as with oral temperature.

2. PULSE

a. WHAT IS THE PULSE?

Each time the heart beats it pushes blood out into the arteries. This causes them to expand because of the increased pressure. This expansion is called the PULSE. The usual place to feel the pulse is on the inside of the wrist. This is called taking the pulse or counting the pulse rate. The purpose is to count the number of times the person's heart beats per minute.

Just as with the other norms, pulse rate varies widely. Some adults may have a pulse rate as slow as sixty per minute or as fast as one hundred per minute, and this can be normal, but the usual adult pulse rate is between sixty to eighty per minute. Children's pulse rates are considerably higher. A newborn baby's pulse may be one hundred and twenty. A three year old may have a normal pulse of one hundred.

Many things cause the pulse to be abnormal. That is why it is important to know what is normal for a person. We can then have an idea when his/her pulse is abnormal.

Some reasons for a faster pulse rate are: strong emotions such as fear, anger, surprise, pain and fever.

b. WHAT YOU NEED TO DO/WHAT TO TELL THE CHILD

1. Watch with a second hand.
2. Explain that you are going to count the pulse or heart beats.
3. If the parent or child is interested, locate your own pulse and let them feel it. People are usually interested in bodily functions and this may also help the child to know that you are not doing something mysterious, so that he/she will not be afraid.
4. Have the child sit comfortably with his/her arm either on his/her lap or resting on a table.
5. Place your first, second and third fingers on the inside of the wrist and press gently against the wrist bone, rest the thumb on the back of the child's wrist.
6. Apply only enough pressure so you can feel the pulse.
7. When you feel the pulse well, look at the second hand on your watch. Count the number of beats for thirty seconds. Multiply that number by two to give the rate for one minute. If you wish, you can count for the full minute.
8. If it seems abnormal in any way, count it again or have the nurse check it too.
9. Say the numbers out loud; write them down. Say something to the child and parent. For example, "Your heart is beating just fine," or "Your heart is beating ninety times per minute. That is the same as most four years old."
10. Record the pulse rate in the child's record.

NOTE: The pulse should beat in a regular rhythm. After you have taken several pulse rates you will know how this feels. If the pulse beats irregularly, this should be reported to the doctor so that it can be checked.

3. RESPIRATION

a. WHAT IS RESPIRATION:

Respiration or breathing is the process the body uses to take in oxygen and get rid of gasses it does not need. The rate and depth of respirations are controlled by the brain. Breathing is automatic just like the heart rate. Breathing should be quiet and regular.

An adult usually breathes sixteen to twenty times a minute. This means that his rate of respiration is sixteen to twenty. A baby may have a normal respiratory rate of forty while a three year-old will breathe twenty-five to thirty times per minute.

b. WHAT INFLUENCES RESPIRATION:

Respiration is influenced by a number of things. Illness, fever and emotional upset will cause the respiratory rate to increase. Some drugs or pressure on the brain will cause the respiratory rate to decrease.

c. WHY TAKE RESPIRATION:

The purpose of taking respiration is to find out the respiratory rate per minute and this will help to find out whether the child is well.

d. WHAT YOU NEED:

A watch with a second hand.

e. WHAT YOU NEED TO DO/WHAT YOU DON'T TELL THE CHILD:

1. DON'T tell the child what you are going to do. If he/she knows you are watching him/her breathe, it is hard for him/her to breathe normally.
2. If possible count the respirations while you are taking the pulse.
3. Watch the rise and fall of the child's chest.
4. Using your watch, count the number of rises per minute - or for thirty seconds and multiply by two. Respirations should be regular. If you have any questions about the child's respirations have the nurse check them also.
5. Write the respiratory rate beside the pulse on the child's record.

NOTE: The TPR are always written in this order: Temperature, Pulse, Respiration. For example: T - 99.2, P - 104, R - 26 or TPR - 99.2 - 104 - 26.

4. COLLECTION OF A CLEAN CATCH URINE SPECIMEN

The kidneys play an important part in keeping the body fluids in proper balance. They take up waste products that the body does not need from the blood, mix them with liquid supplied from the things we drink, and pass this urine through ureters into the bladder where it is stored until we void or urinate. The amount of urine a person voids will depend on how much he/she drinks. It is important to drink enough to wash out the wastes. An adult needs to drink at least six to eight glasses of liquid a day. A child may need less than that depending on his size.

Normal urine is a golden yellow color and it has an odor we recognize. Some food and drugs make urine smell differently. Normal urine is clear not cloudy. Urine is sterile; that is, it has no germs (bacteria) in it. Bacteria are found outside the urinary tract on the body, under the labia, around the vagina and around the anus of a girl, and on the end of the penis, under the foreskin and around the anus of a boy. That is why when we want a urine specimen we must clean these areas.

a. WHY TAKE A URINE SPECIMEN?

We can learn a lot about a person's health when we know what is in his/her urine. The main things we test urine for are glucose, acetone, protein, PH (acid or alkaline), specific gravity, and urobilinogen.

b. WHAT IS TESTING URINE CALLED?

The examination of urine is called a urinalysis.

c. WHAT DO YOU USE?

A labstix and a microstix. The microstix tells us if there is bacteria in the urine. The labstix gives us the other information mentioned above.

d. WHAT YOU NEED:

1. A clean bathroom with a toilet.
2. Paper towel.
3. Toilet tissue.
4. Soap
5. Clean container for the urine.
6. Soap solution, zephiran, or betadine solution.
7. Labstix
8. Microstix
9. Trash can for waste.
10. Paper and pencil or pen.
11. Child's medical record.

e. WHAT YOU NEED TO DO/WHAT TO TELL THE CHILD:

1. Ask the child or parent when he/she went to the bathroom last, and if he/she needs to go.
2. If the child says he/she can void (urinate), you are in luck. If the child says that he/she can not tell give them liquids during the time he/she is there so that they will be able to urinate before leaving.
3. When the child says he/she can urinate, tell him/her you will help him or her and that it is important to get some clean urine. You will need to cleanse area with soap and water.
4. How To Clean a Boy:
 - a. If he has a foreskin, push it back and clean off all the smegma (cheesy-like) material with the cleansing solution; throw away used cotton ball.
 - b. Take a clean cotton ball that has been dipped in cleansing solution and begin at the meatus and go around the tip of the penis. Wipe three times.
 - c. Tell child to stand over the toilet and urinate; let him void a little and then use the clean cup to catch some of the urine.
 - d. You will need enough to dip the microstix and labstix well into the urine. Dip the microstix first, then the labstix second.

5. How To Clean a Girl:

- a. Have the little girl sit backward on the toilet seat. This will separate her legs and make it much easier for you. Be sure you can see well what you are doing. You DON'T want to hurt the child and you want to be sure you cleanse the area well.
 - b. Place cleansing cotton balls within easy reach.
 - c. Squat down beside the child. You may need to tell her that you are going to wash her, since she may be afraid.
 - d. With your thumb and forefinger of one hand separate the labia. With the other hand take a cotton ball that has been dipped in cleansing solution. Going from front toward back, cleanse one side of meatus. Discard the cotton ball.
 - e. Acquire another cotton ball and cleanse the other side of the meatus again going from front toward back. Discard cotton ball.
 - g. With another cotton ball cleanse directly over the meatus, also in a front to back stroking motion. This won't be quite as easy to do because the child will probably tighten up when she feels the solution.
 - h. When child is clean, tell her to urinate. Let child urinate a little first; then catch the rest in your container.
 - i. Give her some tissue to wipe herself.
6. Praise the child for cooperating. You may let him/her watch you test the urine. Have the child wash his/her hands. Now you are ready to record your findings on the child's medical record.

NOTE: If the female has discharge or a large collection of cheesy - like substance, you should inform the doctor.

5. BLOOD TESTING

You will not be doing blood testing. This must be done by a licensed laboratory technician, a registered nurse, a pediatric nurse practitioner or the physician. You may be asked to assist by holding the child.

WHAT YOU NEED TO DO/WHAT TO TELL THE CHILD:

1. Tell him/her that the doctor or nurse is going to take some blood from his/her arm. They need to test the blood to make sure he/she is well.
2. Tell him/her it will hurt, but not for long.
3. Show him/her the needle.
4. Tell him/her it is okay to cry and be scared.
5. Tell him/her you are going to hold him/her. That will make things easier for him/her and the nurse or doctor.
6. Sit on a regular sized armless chair.
7. Have the child sit on your lap.
8. Roll up the child's sleeve, past his/her elbow.
9. Hold the child's arms down firmly with one hand.
10. Hold his/her legs firmly with your other arm. The object is to prevent the child from moving. Sudden movements may cause the needle to break in the child's arm.

MODULE FIVE: THE EYE & EYE SCREENING

OBJECTIVE

The trainee will participate in the screening of children for problems of the eye.

SECONDARY OBJECTIVES

1. Name the parts of the eye, their location and purpose.
2. Specify the steps taken in the examination of the eye.
3. Identify the purpose of the eye examination.
4. Recognize the common problems discovered by eye screening.
5. Apply these principles in preparing the child for examination and assisting the child throughout examination.
6. Identify problems of the eye that are the most frequent complaints of children.

INTRODUCTION

Our sense of sight intertwines with all our waking activities, and leaves sensory imprints that in sleep we jumble into dreams. Through our eyes, awareness of near and far away events streams instantly and constantly into the decision making mind, and like none of the other senses, sight can turn from the page you are reading to a star a million light years away.

1. WHAT IS THE EYE

The **EYEBALL** or **GLOBE** is a sphere about one inch in diameter. It is somewhat inflated by internal fluids, and turned by its own muscles.

The eyeball rests in a bony socket called the **ORBIT** that tapers from frontal bones. This bony socket receives structure attachments, and is pierced to admit nerves and blood vessels. The tip of the cone has an opening through which the **OPTIC** nerve passes from the back of the eye to make connections with the brain. A semi-fluid mass of fat gives cushioning support to the eye and allows it to move freely.

About a half-dozen muscles rotate the eye and turn it up, down, or sideways. They also hold the eye straight. This process is more complicated than it seems since we have two eyes and they have to work together like a team.

There is always a dominant eye. You can determine which it is by making a circle with thumb and forefinger and looking through it, with both eyes open, at an object across the room. Without moving thumb and forefinger, first close one eye and then the other. The eye which still sees the object through the circle is dominant.

2. PARTS OF THE EYE

- A. The cornea: The transparent window of the eye: the visible bulge.
- B. The anterior chamber: Contains watery fluid.
- C. The iris: The colored part of the eye; it gives our eyes color. It has a hole in the center - the pupil - which adjusts to admit more or less light.

- D. The crystalline lens: Changes shape for focusing.
- E. The posterior chamber: Contains semifluid vitreous humor.
- F. The retina: Located at the back of the eye. Light waves are transmitted here.
- G. The choroid: Thin layer with many blood vessels.
- H. The sclera: The white of the eye. The strong outer coat of the eye, made of elastic connective tissue.
- I. The OPTIC NERVE: Takes "sight" messages to the brain. The brain interprets these messages and we see.

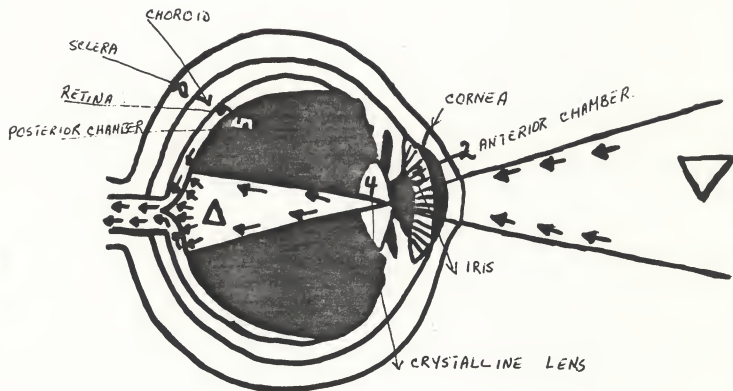
3. HOW WE SEE (Refer to diagram of the eye page 81.)

In order for us to see, several things must happen. Light waves from the object in view are transmitted to the retina (6) at the back of the eye as shown by the arrows. The image is upside down. Light waves are bent as they pass through the cornea (1), and the crystalline lens (4), which changes shape for focusing. The iris (3), the colored part of the eye, houses the pupil, which adjusts to admit more or less light. The anterior chamber (2) and the posterior chamber (5) contain protective fluids. The sclera (8) is the protective outer coat of the eye. It is underlaid by the choroid (7) which gives the eye its nutrients. In the retina (6), light stimulates nerve endings, and nerve impulses travel over the optic nerve (9) to the brain. The brain interprets the messages and we see the object clearly in upright position.

4. WHY DO WE NEED EYE EXAMINATIONS?

The purpose of eye examinations is primarily to determine if an individual is seeing properly. Even if a child does not see properly, glasses may or may not be indicated. Other problems may be present.

DIAGRAM OF THE EYE:



5. WHAT ARE SOME COMMON EYE PROBLEMS?:

- A. The ocular muscles may or may not be working. Ocular muscle imbalance may show itself by the eyes being crossed or divergent. This condition may be congenital but may not become obvious until the child is about two or three years of age. The condition requires diagnosis and proper care. An eye that turns in or out in early childhood may lose its vision unless treated. This is known as AMBLYOPIA from non-use. If discovered and treated early, vision can be restored. No child will outgrow "cross eye." It must be treated. Sometimes glasses or covering the good eye will correct the problem. In some instances surgery is indicated.
- B. STRABISMUS Or Squint: This is a vertical imbalance of the muscles. The most common form of squint is "concomitant convergent strabismus." There is an inward turn of the left eye and the faulty relationship of the axis is maintained in every direction of turn. The condition is often associated with hyperopia or farsightedness. In some instances a child may have alternating strabismus even if vision is perfect in each eye. For example, when he/she looks at an object with his/her right eye, the left eye turns in and viceversa. In this instance surgery makes the eye appear to be straight. It is essentially a cosmetic procedure, but vision is still alternated between the two eyes.
- C. Infections Of the Eye: Bacteria or viruses get into our eyes all the time. If the organism is stronger than the immunity or resistance of the ocular tissue, or if there is a cut on the surface of the eye, infection takes place. If it attacks the white of the eye, the eye becomes red, feels sandy, and discharges fluid.
 1. Pink-eye or acute conjunctivitis. This can be transferred from one eye to another, or to another person's eyes by fingers or a cloth. Pink-eye should be treated early. Many antibiotics are effective in treatment of pink-eye. There is no pain but there is a gritty, sandy feeling. The eyes are stuck together upon awakening.

2. Stye. If bacteria gets into the roots of the eyelashes a local infection takes place. This is called a stye or hordeolum. Styes need to be surgically opened and drained of their contents. An embedded foreign body in the eye can cause serious damage and can result in loss of eye.
 3. Trachoma: The trachoma virus attacks the conjunctiva. This is a steadily progressive disease which leads to eventual blindness, due to the ulceration and scarring of the cornea. This disease is not very common in the U.S., but it is a common cause of blindness in the Middle East, Africa and some parts of Asia. Lack of hygiene, malnutrition, and filth are factors that cause trachoma.
- D. Red Eye: If there is no pain or blurred vision, red eye may mean that a hemorrhage from a ruptured small blood vessel under the conjunctiva has taken place. This is very common among older people. It may be caused by a sneeze, or sudden compression of the abdomen. It looks awful, but the patient may be unaware of it, unless he/she looks in a mirror. It is deep red at first, then changes to purple, green, yellow and finally in about six days fades away. Unless reddened eyes result from something obvious, for example, smoke, the cause should be investigated.

There are two conditions that produce the red eye with pain or blurred vision:

1. Iritis is an inflammation of the iris. The cause is frequently unknown. What is certain is that the tissues of the iris and other parts of the eye become sensitized to a particular protein in the body. In acute iritis the eye is red especially around the cornea. The eyeball is tender to the touch. It is quite painful and vision may be blurred. Iritis needs immediate attention.
2. Acute Glaucoma often begins as a congested eye with mildly blurred vision, associated with headache. A frequent symptom is seeing rainbow rings around street lights. The congestion becomes increasingly worse, vision fades and may disappear. Pain becomes very severe, and the patient may go into a form of shock - sweating, fainting and vomiting. Everytime an attack occurs more damage is done. Immediate medical attention is needed. Treatment is surgical and is very effective.

There is a form of glaucoma that occurs in babies and children under two. This is called congenital glaucoma. The symptoms are sensitivity to light, spasm of the lids, and watering eyes. Sometimes there is pain. Signs that demand attention are an unusually large cornea, often cloudy or hazy, which increases in size, and a deep anterior chamber. The cause is faulty development of the anterior chamber with tissue that covers and blocks the outflow channel. Treatment is always surgical.

E. Cataract is a biochemical change in the eye; with age, in such diseases as diabetes, the eye loses transparency and becomes opaque, gradually shutting out vision. Treatment is surgical. After cataract surgery the lens is gone. An eye without lens cannot focus. It is necessary to supply this lack by "cataract glasses." These are very thick and heavy glasses. Special contact lenses are now frequently being used.

F. Allergies: Itching, redness, watering and swelling of the eyes or the lids are the chief symptom of allergy. Allergies may be caused by drugs or medicines, environmental dust, cosmetics, newsprint, carbon paper, foods and many other things. Home remedies should not be used since treatment is as diverse as the cause.

6. EYE EXAMINATION VERSUS EYE SCREENING:

An eye examination is a very detailed procedure that must be done by an ophthalmologist or an optometrist. (see definitions in glossary). A competent examination of the eye requires the use of a number of special pieces of equipment. By performing a complete examination of the eye, diagnoses can be made.

Eye or vision screening, on the other hand, is a quick surface check for visual acuity, amblyopia and strabismus. This is usually done by a nurse, nurse's aide or a technician. If, as a result of the screening, you have any question, no matter how minor, about the child's ability to see, a referral to an ophthalmologist or an optometrist must be made.

7. TO COMPLETE VISION SCREENING:

a. WHAT YOU NEED:

1. A blank wall.
2. The regular Snelling Chart if the child can read, or the Snelling E Chart for pre-school children.
3. A goose neck lamp.

4. A partial blindfold - cover one eye at a time.
5. Child's record and pen or pencil.
6. A ruler or yardstick.
7. Blank paper to partially cover the chart. This would allow the child to focus on the particular line of the chart to which you are pointing.
8. Twenty feet of floor space from the chart to where the child will stand.

b. WHAT YOU NEED TO KNOW:

When completing vision screening, the child should stand twenty feet from the chart. Looking at an object at twenty feet, the normal lens is relaxed into its normal biconvex shape.

c. WHAT YOU NEED TO DO/WHAT TO TELL THE CHILD:

1. Tell him/her that you are going to check to see how well he/she can see.
2. Show him/her that you are not going to use any equipment; you just want him/her to read the chart, or show you with his/her hand the way the E is pointing.
(The chart you use is dependent on the child's age and ability to read.)
3. Tell the child that you want him/her, during the examination, to cover one eye at a time. Tell him/her you will let him cover his/her eye. You will tell him when.
4. Reassure the child that this part of the physical examination will not hurt.
5. Have the child stand at the indicated line. (Put some masking tape to indicate the place to stand.)
6. Point to the line that you want the child to read. Remember you start at the 20/20 line and move up or down depending on how the child responds.
7. Repeat your instructions often; remember you are dealing with young children. You want to ensure that they understand and remember your instructions.
8. Go over the same letter or line at least twice. This is to ensure that the child has given the correct responses.
9. Record the results on the child's health form.

10. Constantly encourage the child and praise him/her for his efforts.
11. For the next step, tell the child that you are going to put your pen on the tip of his/her nose and you want him/her to follow it with his/her eyes.
12. Show the child by doing the procedure yourself. Let him/her hold the pen if he/she needs this reassurance.

MODULE SIX: THE EAR & EAR SCREENING

OBJECTIVE:

The trainee will participate in the screening of children for problems of the ear.

SECONDARY OBJECTIVES

1. Name the parts of the ear, their location and function.
2. Specify the steps taken in the examination of the ear.
3. Identify the purpose of the examination.
4. Recognize common problems discovered by screening the ear.
5. Identify problems of the ear of which children usually complain.
6. Apply these principles in preparing the children for examination of the ear and assisting children throughout the examination.

INTRODUCTION

Our auditory system is one of the most sensitive and discriminating of senses, able to distinguish puffs of air coming from a particular voice or a particular instrument in a symphony orchestra. It is well protected by the location of its most delicate structures within hard bony areas of the head.

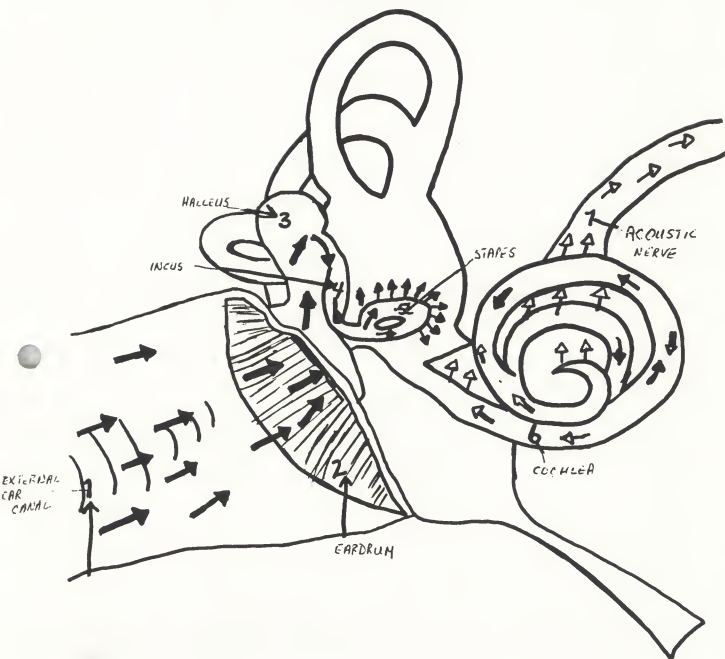
I. PARTS OF THE EAR: EXTERNAL, MIDDLE & INNER

- A. The External Ear is largely ornamental, but it does help to direct sound waves into the ear canal. The external ear consists of:
 1. The Pinna - appendage on the side of the head.
 2. The ear canal penetrates about an inch into the head. It has the ear drum or tympanic membrane at its end. The ear drum separates the external ear from the middle ear.

- B. The Middle Ear is an air-filled cavity sealed by the ear drum and surrounded by its bony walls. There is an opening which leads to the mastoid bone, and a tubular passage which opens into the throat called the Eustachian tube. An amplifying system is built into the middle ear. This consists of three bones called the ossicles. The ossicles are the malleus or hammer, the incus or anvil, and the stirrup or stapes. The ossicles move whenever the ear drum moves. They carry vibrations across the middle ear to the inner ear. The ossicles are the smallest bones in the body. They are fully grown at birth. The stapes fit into an opening called the oval window. The oval window lies between the middle ear and the vestibule. Movements of the stapes causes movement of the fluid of the vestibule. This movement excites the nerve endings in the cochlea and travels along the auditory branch of the eighth nerve to the brain, causing the sensation of hearing.
- C. The Inner Ear is a complex bony structure filled with fluid and three main parts: (1) semicircular canal, (2) cochlea, (3) vestibule. The cochlea is a tubular bony structure containing thousands of hair cells tuned to vibrate to different sounds. Nerve endings are contained in a complex structure over the floor of the cochlea. This area, called the organ of the corti, is the center of the sense of hearing.

(See Diagram of the EAR next page)

DIAGRAM OF THE EAR



2. HOW DO WE HEAR?

(Check DIAGRAM for numbered parts of the EAR)

Sound waves entering the external ear canal (1) cause the ear drum (2) to vibrate. In the Middle ear, vibrations are amplified and transmitted by a chain of ossicles, the malleus (3), incus (4) and stapes (5). The malleus is attached to the ear drum. A portion of the stapes touches the cochlea (6), and sends vibrations to fluid in the labyrinth. The cochlea contains many hair cells tuned to vibrate to different frequencies. Nerve endings transmit impulses via the acoustic nerve (7) to receiving areas in the brain, and we hear.

3. WHAT IS IMPAIRED HEARING?

Essentially impaired hearing is the inability to hear at varying levels. Very few people in the U. S. are totally deaf, but approximately six million have some degree of hearing loss. There is a steady loss of hearing acuity as we grow older. The normal ear can hear tones with a range of sixteen cycles per second to twenty thousand cycles per second. A sixty-year-old person can usually not hear sounds of more than twelve thousand cycles per second.

The pitch of human speech ranges between three hundred and four thousand cycles per second. Inability to hear well within this range is a serious handicap.

4. TYPES OF HEARING LOSS

A. Conductive Deafness is failure of airborne sound waves to be conducted efficiently through and over external and middle ear structures, so that adequate messages do not reach the nerves of the middle ear. Causes of this are: (1) ear wax, which obstructs vibrations; (2) pus-forming middle ear infections; (3) congenital malformations; (4) otosclerosis: an overgrowth of bone at the point at which the stapes deliver vibrations to the inner ear.

- B. Nerve Or Perceptive Deafness is failure of the auditory nerve to perceive, accept and transmit messages to the brain. Nerve deafness can be complete or partial. Causes: (1) congenital e.g. infection of mother during pregnancy with German measles; (2) infections: High fever, meningitis, measles, etc.; (3) certain drugs e.g. quinine and streptomycin; (4) blows to the head and skull fractures; (5) advanced infections of the middle ear; (6) prolonged exposure to intense noise.

5. TYPES OF EAR INFECTIONS

A. External Ear Infections

1. Boils in the ear canal. These are very painful and immediate medical attention is needed. They are caused by poking and picking at the ear with pencils etc. or putting foreign bodies in the ear.
2. Fungus Infection: Often referred to as "summer ear". This is caused by moisture in the ear. Usually the skin is itchy and crusty. It can be painful if swelling occurs. Various ointments are effective forms of treatment. However, since there are different kinds of causative organisms, selection of the proper medicine must be made by a physician.

B. Middle Ear Infections

Products of infection trapped in the middle ear press against the ear drum and distend it, and may force their way into the mastoid and reach the brain. The real danger of middle ear infections is its complications. Children are especially prone to middle ear infections because their eustachian tubes are shorter and straighter than adults.

1. Acute Middle Ear Infections are indicated by intense stabbing pain. Antibiotics and similar drugs are the available treatment techniques. If perforation of the eardrum appears imminent a myringotomy - a small incision in the eardrum to allow drainage - may be performed.
2. Chronic Middle Ear Infections are usually associated with infected tonsils and adenoids, allergies or recurrent discharge through a perforated ear drum. Membranes become thickened and the Eustachian tube constricts. Early diagnosis and treatment are important to avert the threat of hearing impairment.

6. LEVELS OF HEARING LOSS

- A. Mild hearing loss: Hearing loss in the range of 20 db to 40 db.
 - B. Moderate hearing loss: Hearing loss in the range of 40 db to 60 db.
 - C. Severe hearing loss: Hearing loss in the range of 60 db to 80 db.
 - D. Profound hearing loss: Hearing loss of more than 80 db.
- (Note: db refers to decibels).

7. SIGNS OF HEARING LOSS

- A. Lack of attention.
- B. Failure to follow instructions.
- C. Difficulty in hearing bells, buzzes or knocking.
- D. Frequent request for repetition of speech.
- E. Misunderstanding of person to person conversation.
- F. Imperfect language skills.
- G. Educational difficulties.

8. WHAT ARE TESTS OF HEARING?

Hearing examinations are standardized techniques which enable hearing loss to be measured in terms of loss of decibels. There are a number of highly specialized testing devices that are used by otologists (ear physicians) and audio-clinics. Two instruments are usually used when hearing screenings are done - the audiometer and the impedance meter.

- A. An audiometer is an instrument which emits puretones which can be turned up louder, decibel by decibel. Audiometric screening requires a voluntary response from the child when he hears the tone. Audiometric screening measures primarily conductive hearing loss.
- B. An impedance meter is an instrument designed to measure conductive as well as sensory-neural hearing impairments and to differentiate between these two kinds of impairments. The acoustic reflex test can help the otologist recognize a non-organic hearing impairment. Impedance screening does not require a voluntary response from the child.

C. WHAT YOU NEED TO KNOW:

1. Be thoroughly familiar with the instrument that your particular agency uses. Practice with it, read all available material. Do not attempt to test a child unless you are thoroughly familiar with the machine.
2. Your role is first to assist the technician and finally to do the hearing screening yourself. Your testing needs to be as accurate as possible.
3. You must become very familiar with the type of written record used by your agency. When audiometric screening is done you get an audiogram; when impedance screening is done you get tympanogram. The type of record used may vary with the agency. Accurate recording of the results is very important.
4. Young children will often be scared. You will need to reassure them.

D. WHAT YOU NEED:

1. The audiometer and/or impedance meter.
2. A child size table.
3. Two chairs (one for the child; one for you)
4. Paper and pencil or pen.
5. The child's record.
6. A sound proof room ideal but a quiet room with a door will suffice.
(Reduce distraction as much as possible).

E. WHAT YOU NEED TO DO/WHAT TO TELL THE CHILD:

1. Have the child sit down.
2. Tell the child that you want to see how well he/she can hear.
3. Let the child see the machine, explain the parts of the machine to him/her and let him/her touch the dials, especially the part that will go into his/her ear.
4. When the child is ready, put the ear phone on his ear.
5. Proceed with the hearing testing. The process may differ slightly depending on the machine that you are using.

- F. Record your results.
- G. If you question the accuracy of your results - RETEST.
- H. Bring any abnormal or questionable findings to the attention of your doctor.

MODULE SEVEN: COMMUNICABLE/INFECTIOUS DISEASES COMMON TO CHILDREN

OBJECTIVE

The trainee will recognize children who are ill and apply principles of disease control in treatment of these children.

SECONDARY OBJECTIVES

1. Identify organism that causes illness (bacteria, virus, fungus, etc.)
2. Specify the symptoms commonly seen when such organisms cause illness in children.
3. Specify common childhood illnesses that are contagious.
4. Describe how illnesses are passed from child to child.
5. Specify the techniques for limiting the spread of infection.

CONTENT

The following is a chart on infectious diseases that has been adapted from the Better Homes and Gardens, Family Medical Guide.

CHART OF INFECTIOUS DISEASES

SOURCE	MODE OF TRANSMISSION	INCUBATION PERIOD
CHICKENPOX Virus closely related to, the virus causing shingles. In secretions of nose and throat of infected person.	By direct contact with person who has the disease.	12 to 19 days (usually 13th or 14th day).
DIPHTHERIA Diphtheria bacillus. In secretions of nose and throat of infected person or carrier.	By direct contact with infected person or carrier, or by contact with articles infected by patient or carrier, or through contaminated milk.	Usually 2 to 6 days.
GERMAN MEASLES Virus in secretions of nose and throat of infected persons.	By direct contact with person who has the disease.	14 to 25 days (usually 17 or 18th day).
HEPATITIS Hepatitis virus in feces and possibly in secretions of nose and throat of infected person.	Mostly by feces of infected person. Possibly contracted by nose and throat secretions of infected.	10 to 50 days (average 25 days).

PERIOD OF CONTAGION	TYPE OF RASH	SIGNS & SYMPTOMS
CHICKENPOX From 1 day before appearance of rash to 6 days after appearance of rash.	Rash begins as small pink spots which develop into pinhead-size pimples, then a tiny blister forms on top of pimple which turns to scab in about 4 days. Rash covers whole surface of body including scalp.	Fever and headache, follow- ed by appearance of rash within 24 hours. Rash fully out in 2 to 3 days, followed by drop in temperature. Itching of lesions usually subsides by 4th day.
DIPHTHERIA Period of contagion usually two weeks or less. Con- tagion considered over when 3 successive nose and throat cultures are negative at intervals of 25 hours.	None.	Headache, fever and severe sore throat with confluent white exudant forming over tonsils, throat and soft pa- late. Fever, cough and bloody discharge from nose.
GERMAN MEASLES From start of symptoms to at least 4 days after. Conta- gion considered over 3 days after onset of rash.	Rash which may be mottled or made up of tiny pimples usually appears first on face and neck and works down, covering whole body in 12 to 24 hours.	Symptoms usually mild, with low grade fever and occasional headache. There are usually swollen glands behind neck and on back of head. These appear either before or during appearance of rash. Eyes may be slightly inflamed.
HEPATITIS Unknown. Virus may be in feces 2 to 3 weeks before onset of disease and at least during acute stage.	None.	Early signs are malaise, weakness, headache and loss of appetite. Then right upper abdominal discom- fort and pain, nausea and vomiting, usually occur. Urine is dark, feces light. Some afterward jaundice appears.

TREATMENT	CARE OF EXPOSED PEOPLE	IMMUNIZATION (PROPHYLACTIC)
CHICKENPOX No specific treatment. Cut fingernails, apply drying and anti-itching lotion such as calamine lotion with 10% phenol, anti-itching baths. Antihistamines by mouth may also be very helpful.	None.	None.
DIPHTHERIA 1. Diphtheria antitoxin. 2. Penicillin 3. Erythromycin	Penicillin by injection and also by mouth for 5 to 7 days.	Diphtheria toxoid with booster inoculations given at periodic intervals.
GERMAN MEASLES No specific treatment.	Usually none given on desired except for exposed women in first three mths. of pregnancy who have not, to their knowledge had German Measles. A blood test should be made to see whether or not they have immunity.	Live German Measles virus vaccine will immunize for long period of time but the degree and duration of immunity is not fully determined. It should be given to all children and especially to girls approaching puberty.
HEPATITIS None specific. In severe cases with liver damage, corticosteroids may be used.	Infectious gamma globulin usually protect for 5 weeks or longer.	Temporary immunization for 5 weeks or longer may be obtained with injections of gamma globulin.

SOURCE	MODE OF TRANSMISSION	INCUBATION PERIOD
INFLUENZA Influenza viruses. Usually Type A, Type B, or Asian type, in secretions of nose and throat of infected persons.	By direct contact with infected person, or by articles recently contaminated by infected person.	Usually 1 to 3 days.
MEASLES Virus in secretions of nose and throat of infected persons.	By direct contact with person who has the disease.	7 to 14 days (usually 10 days).
MENINGITIS Meningococcus bacteria in secretions of nose and throat of infected persons.	By direct contact with infected person or carrier.	1 to 10 days (usually 3 to 7 days).
MUMPS Virus of mumps in saliva of infected persons.	By direct contact with person who has the disease.	14 to 21 days. Average 17 days.

**PERIOD OF
CONTAGION**

**TYPE OF
RASH**

**SIGNS &
SYMPTOMS**

INFLUENZA

Shortly before and up to 1 week after onset of symptoms.

None.

Usually sudden onset with headache, malaise, chills, and aches and pains in arms, legs and back. Nose congested. Hard, dry cough common.

MEASLES

From 4 days before until 5 days after rash appears.

Mottled, slightly elevated pink rash appearing first on face and neck and extending down over whole body within 3 days. Then starts fading from head down.

Fever usually 3 or 4 days, followed by hard, dry cough, red eyes and running nose. Tiny white spots (Koplik spots) then appear on inner cheeks, gums and palate. Then fever rises high as rash appears and continues for several days.

MENINGITIS

As long as the bacteria remain in the nose and throat of infected person.

Tiny dark red spots appearing mainly on trunk and buttocks in about 40% of cases. May last only a few hours.

Fever, headache, vomiting. Later delirium and loss of consciousness. Stiffness of neck is a fairly constant sign.

MUMPS

Until swelling of infected glands have completely subsided.

None.

Occasionally fever and vomiting, but often no signs or symptoms before tender swelling of other side of face appearing in 2 or 3 days, or at times not appearing.

TREATMENT

CARE OF EXPOSED
PEOPLEIMMUNIZATION
(PROPHYLACTIC)

INFLUENZA

No specific treatment.

None.

Polyvalent vaccine against known viruses causing influenza. Yearly booster injection to maintain immunity.

MEASLES

No specific treatment. Antibiotics often used to prevent complications.

Measles may be prevented or modified by injections of gamma globulin during incubation period. Treatment must be early to prevent the disease. Gamma globulin during incubation period. Treatment must be early to prevent the disease.

Live measles virus vaccine will immunize for long periods, possibly for life. May develop a fever in 6 to 8 days. Killed measles virus protects from 2 to 3 years. No reactions.

MENINGITIS

Penicillin or sulfa preparation in effective if given in early stages.

Penicillin or sulfonamides by mouth as prescribed by physician.

None.

MUMPS

No specific treatment recommended in infants and children.

Immediate immunizations of susceptible persons is provided by hyperimmune mumps globulin. This immunity is temporary, lasting only a few weeks.

Live mumps virus vaccine gives long immunity, probably for life. It should be given to all children, especially boys, before puberty.

MODULE EIGHT: IMMUNIZATIONS - CONTROLS OF COMMUNICABLE DISEASE

OBJECTIVE:

The trainee will distinguish those children who have been immunized and those who have not. In addition, the trainee will be able to interpret for the parent or care-taker why immunizations are important for health maintenance.

SECONDARY OBJECTIVES

1. Define antibody and antigen.
2. Describe how disease is preventable through immunizations.
3. Specify which illnesses are preventable through immunizations.
4. Identify the childhood schedule for immunizations.
5. Relate childhood illness to its effect upon child growth and development.

1. INTRODUCTION

A. Some Words To Know:

1. Antibody: A substance made by the plasma cells in the blood when a specific disease-causing agent (virus, bacteria) enters the body. These build resistance.. (See Table Page 104).
2. Antigen: A disease-causing agent foreign to the body that causes the body to produce antibodies.
3. Active Immunity: A "live" vaccine given to cause people to have a mild case of the disease or to produce antibodies to prevent them from getting the disease. This immunization serum lasts a life time.
4. Passive Immunity: Serum from a human or animal, that already has antibodies in it, is injected. This type of immunization serum does not last a life time. It lasts for about three years.
5. Immunity: A person has enough antibodies in his/her body to resist catching a disease.

2. SOME IMPORTANT THINGS TO KNOW ABOUT IMMUNIZATIONS

- A. About one-third of the children in the United States have not been immunized. Since two-thirds of the children have had immunizations, there are fewer cases of disease, as a result some parents do not see the importance of immunizations.

- B. It is very important that a record is kept on each child. A copy of this record should be given to the doctor. If there is no record, the clinic or doctor will have to give the immunizations again. This can be dangerous as well as painful for the child.
- C. Immunizations help the child build up resistance to common diseases.
- D. Immunizations reduce the mortality (death) rate.
- E. Immunizations prevent serious side effects that can result from having the disease.
- F. Immunizations help improve general health and increase life expectancy.
- G. A baby less than two months old is too young to respond to immunizations.

3. USUAL IMMUNIZATIONS GIVEN:

- A. DPT or DTP: Diphtheria, pertussis (whooping cough), tetanus.
- B. TOPV or OPV: Trivalent Oral Polio Vaccine. These two are given in series (several in a row) to provide basic immunity and maintain a level of antibody in the body; to prevent the disease. The first series is followed by boosters.
 - 1. DPT is an injection (shot).
 - 2. OPV is given as drops on the tongue. The drops are kept frozen until a few minutes before they are given.
 - 3. DPT and OPV are usually given at two, four and six months of age for the original series. Boosters are given at eighteen months of age and from four to six years of age.
 - 4. Contra-indications:
 - a. Illness where the child is febrile (has fever).
 - b. Severe complications after other immunizations.
 - c. Pregnancy, cancer, or a person on steroids.
 - 5. Common reactions may be local or systematic:
 - a. Redness, swelling and pain at the injection site.
 - b. Elevated temperature which may cause convulsions.
 - c. Irritability.

NOTE: TD (tetanus, diphtheria) should be given every ten years as boosters.

C. MMR (measles, mumps, rubella). These three are usually given together as one injection but can be given individually. A single immunization lasts a lifetime so only one is needed. The infant obtains normal immunity from the mother. This lasts for about a year. The MMR is, therefore, not given until the child is year old. The main reason to give rubella is to prevent congenital rubella syndrome. The mild history of the disease is not an accurate reason to omit giving the immunization. The MMR vaccine is a "live" vaccine causing active immunity.

Contra-indications are as follows: (1) Febrile illness or "cold" and (2) Pregnancy.

Common reactions are fever and mild rash five to ten days after the injection in 10% - 20% of those receiving immunizations.

D. Small Pox Vaccination:

There have been no cases of small pox in the United States since 1949. As a result, this injection is no longer given routinely. It should not be given if the person has a rash of any kind. The vaccine must be kept frozen and ready for use.

E. Tuberculosis Screening:

The TB Tine or PPD should be given at about one year of age. This is NOT an immunization. A reaction to this test means that the child has been exposed to tuberculosis. It is important to test regularly (every year or two) to see if the child has been exposed. The TB Tine should NOT be given at the same time as the MMR. It should be given either before or at least one month afterward.

6. SCHEDULE FOR IMMUNIZATIONS IF NOT GIVEN IN INFANCY:

1 - 5 YEARS OLD

OVER 6 YEARS OLD

1st visit: DPT, OPV, TB Tine

1st visit: DPT, OPV, TB Tine

1 month later: MMR

1 month later: MMR

2 months later: DPT, OPV

2 months later: TD, OPV*

4 months later: DPT, OPV

6 - 12 months later: TD, OPV*

6 - 12 months later: DPT, OPV

5. ASSISTING WITH IMMUNIZATIONS

A. If you have established a trusting relationship with the child, tell him/her the truth and stay with him/her. This will be the most important way you can help him/her.

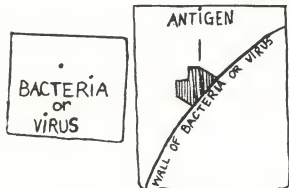
B. You must be prepared to hold the child and **HOLD HIM/HER TIGHT** during the procedure. By doing this you may save the child much anxiety and pain.

C. What You Need To Do:

1. The technician, nurse, or whoever does the immunizations and tests, has a certain way for you to hold the child. If you concentrate on immobilizing the joints, you hold the entire arm still. You also need to remember to keep the other arm, both legs and the head out of the way. Practice some ways to do this.
2. Children do not understand the idea of being hurt to stay well. It is better not to spend a lot of time trying to explain it to them. Just tell them it is going to hurt and it will be over soon.
3. After it's over, stay with the child until he/she is calm and ready to leave. A band-aid and assurance that he/she was "very brave" also helps.

* TD is used instead of DPT for older children and adults. This is important since the strength of the vaccine is different.

ANTIBODY CREATION

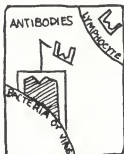


1. A bacteria or virus enters the human body through the mouth, a break in the skin, a mucous membrane, etc. The lymphocytes - a type of white blood cell - discover the bacteria or virus and recognize a protein substance on the wall of the virus or bacteria (called antigen) as foreign, or as not normally belonging in the body.

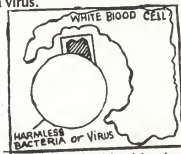


2. The lymphocyte cells create proteins (called antibodies) which are structured in such a way as to join with the specific antigen.

Note: Scale is purposefully distorted. Understand that a lymphocyte is many thousands of times larger than a bacteria or a virus.



3. The lymphocyte releases the antibodies, which it has created, into the fluids of the body, to combine with the foreign proteins on the surface of the bacteria or virus. When combined this renders the virus or bacteria harmless to your body.



4. Another type of white blood cell engulfs the now harmless bacteria or virus and carries it to other parts of the body to get rid of it.

5. This process makes immunization possible. With immunization, virus or bacteria are first rendered harmless though the antigen on their walls remains intact. A small amount of this substance is introduced to your body. Then your body creates antibodies to combine with that specific antigen. Your body has then developed a large stock of those specific antibodies so that if the live virus or bacteria were to come into your body you would already have the "knowledge" and/or the antibodies to easily protect yourself from the infection.

MODULE NINE: FIRST AID

OBJECTIVE

The trainee will be able to administer first aid to a child in case of an emergency or accident, until the arrival of professional medical staff.

SECONDARY OBJECTIVES

1. Identify common hazards to children.
2. Specify the injuries likely to result.
3. Compare the use of heat to the use of cold treatments.
4. Describe techniques for limiting blood loss.
5. Describe techniques for caring for children with broken bones.
6. Describe techniques for caring for children with burns.
7. Describe techniques for caring for children who have injected poison.

1. CONTENT

FIRST AID is just that - First Aid or what to do before the doctor comes. It is NOT A Substitute for medical care. It is a means by which a lay person can take life saving measures in an emergency.

2. SOME COMMON HAZARDS

- A. Medicines
- B. Cleaning fluids/agents
- C. Disinfectants
- D. Insect or rodent poisons
- E. Aerosol products - hair spray, deodorants
- F. Furniture with sharp edges
- G. Matches and Cigarettes
- H. Unattended irons, ovens
- I. Hot pots on a stove
- J. Toys with small pieces - marbles, etc

K. Electrical outlets

L. Some playground equipment - especially those made of metal with sharp edges.

M. Moving swings.

3. WOUNDS, CUTS & BRUISES

A. Stop bleeding (See Page 111).

B. Combat Shock (See Page 110).

C. Keep breathing passages clear of obstruction.

D. Give artificial respiration if necessary (See Page 108).

E. Have someone call a doctor.

4. BROKEN BONES

A. Suspect Bone Is Broken If:

1. Child cannot move injured part.
2. Part is deformed (out of shape).
3. Child is in pain when trying to move.
4. There is no feeling when the injured part is touched.
5. There is swelling and blueness of the skin.

B. What To Do:

1. DO NOT MOVE patient while waiting for the doctor.
2. If child must be moved out of danger, pull at legs or armpit along axis of body.
3. Examine for other injuries.
4. Check mouth or throat for possible obstruction of breathing.
5. Keep air passages clear.
6. Give artificial respiration if needed.
7. Cut clothing away taking care not to disturb the injured part.
8. Keep patient lying down and warm.

9. If neck is injured DO NOT put pillow under head. Rather, block neck movement.
10. If you have to transport the patient:
 - a. Always apply splints before moving the patient.
 - b. Apply clean dressings and bandage if bone protrudes.

5. BURNS

A. Minor Burns: Skin reddened, unbroken, no blisters, small area.

1. Hold immediately under cold running water for several minutes until no pain is felt when the skin is removed.
2. Cleanse with white soap and water.
3. Apply a paste of wet baking soda or gauze with petroleum jelly, or use ointment.
4. Cover with sterile bandage.

B. Major Burns: Blisters, skin broken, and burn covering 10% of the skin area.

1. Immediate step when possible: Wrap the patient in a blanket or sheet and get to the hospital.
2. If step one is not possible:
 - a. Immerse burned part in warm water. If burn is extensive and involves large area, put patient clothed into a bathtub of warm running water. This excludes air from burn and helps prevent shock. Put some baking soda in the water.
 - b. Remove clothing carefully using scissors to cut around cloth that sticks to burned skin. NEVER PULL CLOTHING THAT ADHERES TO SKIN.
 - c. If immersion of burned part is not possible, have patient lie down on a bed on top of a clean sheet. Cover with dry dressings made as thick as possible.
 - d. Warm patient and keep him/her warm while waiting for the doctor.

C. Important DON'TS:

1. DO NOT open large blisters.
2. DO NOT apply any antiseptics.
3. DO NOT apply greases, ointments, butter, unsterile dressings, fluffy cotton, or any material that the doctor will find hard to remove.

6. POISON

A. Swallowed Poisons:

1. Call doctor at once or take child to nearest hospital.
2. Before taking to hospital do the following:
 - a. If patient is conscious:
 1. Before telephoning the doctor, dilute the poison by giving large amounts of fluid. The fluids may cause vomiting; this should be encouraged.
 2. If patient vomits, put in prone position, head turned and lowered over bed edge, to preventing inhaling the ingested material. For a child, hold face downward on your lap, head hanging over.
 3. Induce vomiting by tickling back of throat if patient does not vomit.
 4. DO NOT INDUCE VOMITING if the person has swallowed lye, corrosive acids, kerosene, gasoline or turpentine.
 5. Keep the patient warm, keep him/her breathing.
 - b. If the patient is unconscious, semi-conscious, or in shock:
 1. Keep air passages open: Put patient on stomach with head low, turned to one side.
 2. Wipe mucous from mouth with handkerchief or finger.
 3. Keep tongue from falling back and blocking air passages. Watch for slowed or stopped breathing.
 4. If breathing stops give mouth to mouth, resuscitation immediately. (See Page 109).
 5. Keep patient warm and covered.
 6. DO NOT give stimulants.

7. ARTIFICIAL RESPIRATION:

If a person has stopped breathing FROM ANY CAUSE start artificial respiration immediately. Seconds count. The most efficient way to save a life is to blow your breath into the person's lungs - this is called MOUTH TO MOUTH RESUSCITATION.

A. Mouth To Mouth Resuscitation:

1. If foreign matter is visible in the victim's mouth, wipe it out quickly with your fingers or cloth wrapped around your fingers.
2. For an adult, blow vigorously at the rate of about twelve breaths per minute. For a child, take shallow breathes at a rate of twenty per minute.
3. Tilt the victim's head back so chin points upward.
4. Pull or push jaw in so that it juts out.
5. Open your mouth wide, place it tightly over the victim's mouth. Pinch victim's nostrils shut.
or
6. Close the victim's mouth and place your mouth over the nose.
7. Blow into victim's mouth or nose.
8. Removing your mouth, turn your head to the side to listen for outflow from victim's lungs.
9. If you are getting air exchange, recheck head and jaw positions; make sure mouth and throat are clear and try again.
10. If you still do not get air exchange, turn victim on his side and give several sharp blows between shoulder blades. This may dislodge foreign matter from the victim's throat.
11. If victim is an infant or small child, suspend child by ankles, or hold head down between one of your arms, and give several sharp pats between shoulder blades. This will dislodge obstructing matter from air passages.
12. Continue artificial respiration until the victim begins to breathe on his/her own or until the victim is pronounced dead by a doctor.

B. Back Pressure - Arm Lift Resuscitation:

1. This is not as effective a method as mouth to mouth, but it is an alternative. This can be used only if the victim has no arm injury.
2. Wipe visible foreign matter from the victim's mouth.
3. Place victim's face down, bend his/her elbows, place hands one upon the other.
4. Turn head to one side; extend as far as possible so chin juts out.
5. Kneel at victim's head. Place your hands on the flat of the back, just below and between the armpits.

6. Rock forward until your arms are nearly vertical, with the weight of the upper part of your body exerting steady, even pressure on your hands.
7. Immediately draw the victim's arm up and toward you. Lift enough to feel resistance and tension at his/her shoulders. Lower arms to the ground.
8. Repeat about twelve times per minute.
9. Check mouth frequently for obstruction.

8. SHOCK

Every serious accident, burn, poisoning or injury is always accompanied by shock. Shock is caused by bodily reactions which slow or stop the circulatory mechanisms, and is essentially an insufficient blood supply to vital organs. Expect shock to develop after any serious injury. Take preventive steps before the doctor arrives to take over.

A. Signs Of Shock:

1. Weakness
2. Rapid but weak pulse
3. Pale face
4. Skin cold, clammy with perspiration of forehead, palms
5. Patient may have chills.
6. Thirst
7. Nausea
8. Shallow, irregular breathing
9. Low blood pressure (late sign)

B. Immediate First Aid To Lessen Shock:

1. Deal with any immediate life threatening emergency that the injury requires, e.g., stop bleeding, clear air passages.
2. Have patient lie flat, head level with or lower than the rest of the body, unless the patient has a head injury, in which case, elevate the head slightly.

3. The purpose of lowering the head is to help the blood flow to the heart and brain. If you cannot lower the head, elevate legs to a height of twelve to eighteen inches, if the nature of the injury permits.
4. Cover the patient, protect him/her from cold ground, air, loss of body heat. Keep the patient warm not hot. You do not want to heat the patient. You just want to keep him/her cool.
5. Do not let the patient see the injury. Reassure him/her. Handle him/her gently. Pain and anxiety increases shock.
6. If the patient is conscious, not vomiting, does not have an abdominal injury, give shock solution: one teaspoonful salt, one-half teaspoonful baking soda dissolved in one quart of water. Give patient all that he/she will drink.
7. If available, a cup of strong black coffee or tea is helpful.
8. Get doctor as soon as possible.

9. BLEEDING: HOW TO STOP

- A. Direct Pressure should be applied to deep cuts, severed blood vessels, spurting or oozing blood.
 1. Remove enough clothing to see wound clearly.
 2. Cover wound with sterile compress.
 3. Apply firm hand pressure directly over wound.
 4. Pressure must be firm and steady, not intermittent.
 5. Press with finger, hand, or heel of hand until bleeding stops.
 6. Clean, sterile materials should be used. If they are not available, use materials that are on hand. Blood loss is more dangerous than risk of infection.
 7. If bleeding is in the arm or leg, elevate the limb.
 8. When bleeding stops, apply pressure dressing in the following manner:
 - a. Put gauze compress or folded layers of clean cloth over bleeding point.
 - b. DO NOT use fluffy material or cotton.
 - c. Press compress with fingers and apply bandage to keep dressing in place. Preferably use gauze compress bandage. Bandage must not be too tight. Too tight bandages would cause swelling.

B. Pressure Points:

Direct pressure combined with elevation of limb is the most rapid safe way by which bleeding is controlled. If bleeding does not stop, or resumes as pressure bandage is applied, press with fingers or hand against proper pressure points. The pressure points are points of the body where blood vessels pass over the bone. Pressure applied at pressure points shuts off blood, like clamping a rubber hose.

1. Bleeding from the head above eye level - press with finger against head just in front of the ear.
2. Bleeding below eye and above jawbone - press fingers against notch in jawbone. This notch is about one inch in front of the angle of the jaw.
3. Bleeding from neck, mouth and throat - press thumb against back of neck, fingers on side of neck below Adam's apple at the side of the windpipe.
4. Bleeding from armpit, shoulder and upperarm - place fingers or thumb in hollow behind collarbone. Press against upper surface of first rib.
5. Bleeding from hand, forearm, lower two-thirds of arm - press against arm bone halfway between armpits and elbow, thumb inside arm, fingers outside.
6. Bleeding from palm of hand - place thick pad covered with sterile gauze in palm, close fingers over it, bandage into patient's closed fist.
7. Bleeding from forearm - place pressure pad inside elbow, tighten forearm against pad, bind.
8. Bleeding from foot, leg or thigh - place palm of hand in middle of depression on inner side of thigh, just below fold of groin, press down against bone.
9. Bleeding below knee - pressure pad in back of patient's knee, tighten lower leg against pad, bind.

10. HOW TO MAKE A SPLINT

The purpose of a splint is to give the broken part consistent support, immobilize it and prevent bone ends from grinding together. The splint must be long enough to extend above and below the adjacent joints to prevent motion.

A. Splint Materials:

1. Almost anything that is rigid will serve in an emergency - boards, sticks, floor mat, umbrella, tightly rolled magazine, etc.
2. Hard objects must be well padded with cotton, cloth or other soft material, before placing it in contact with the injured part.

B. Making The Splint:

The specific splint that you make varies depending on the part of the body that is broken. The following are some general instructions. The instructor will go through details for specific splints. You need to practice.

1. Make sure that the splint material is long enough to extend above and below the fractured part. You generally need two, an inside splint and an outside splint. This ensures immobilization.
2. Pad splint by wrapping repeatedly with cotton.
3. Cover fracture site with thick gauze bandage.
4. Put splints on both sides of fractured site.
5. Tie with cotton or gauze bandage.

11. WHAT YOU NEED TO HAVE ON HAND FOR FIRST AID

First aid supplies can be bought from any drug store. They should be kept in a separate container. They should be easily accessible, and kept separate from other medical supplies. They should never contain poisons, and never be locked with a key. Always keep first aid supplies in the same place and return them to that place immediately after use. Replace missing or depleted items promptly.

A. Supplies:

1. Sterile gauze compresses and pads, individually packaged, two, three and four inch square.
2. Sealed roller gauze bandages, one, two and three inches wide.
3. Adhesive roller gauze bandages with gauze pads - assorted sizes.
4. Adhesive tape.
5. Sterile absorbent cotton.
6. Large triangular bandages.

B. Equipment:

1. Scissors
2. Tweezers
3. Safety Pins

C. Medicines and Materials:

1. Tube of petroleum jelly or package of impregnated gauze.
2. Table salt or salt tablets
3. Baking soda
4. Aromatic spirits of ammonia
5. Mineral or olive oil
6. Universal antidote for poisons

D. Other Materials and Supplies (useful but not mandatory):

1. Thermometers (oral and rectal)
2. Ice bag
3. Hot water bottle
4. Eye cup
5. Paper cups
6. Flash light
7. Tongue depressors
8. Cotton-tipped applicators
9. Rubbing alcohol
10. Milk of magnesia
11. Calamine

12. PREVENTING ACCIDENTS OR INJURY

- A. Asphyxiation Tragedies: Children put small objects into their mouths and sometimes swallow or inhale them.

1. Keep beans, peanuts, buttons, pins, beads, coins out of the reach of young children.
2. Do not allow toys smaller than the child's fist.
3. Check for toy parts - eyes from dolls, etc.
4. Never leave a small child alone in a bathtub.
5. Check gas heaters and appliances periodically.
6. Never run a car engine with garage door closed.

B. Electrocution Accidents:

1. Have all switches and appliances in locations that can't be touched from bath, sink, etc.
2. Never have electrical appliances where they can fall into water.
3. Don't touch anything electrical while standing on wet floors.
4. Don't touch anything electrical with wet hands.
5. Have electrical equipment grounded.
6. Replace all frayed electrical cords.
7. Cover unused wall sockets with protective plates or seal with adhesive tape.
8. Never touch a dangling wire.

C. Broken Bones:

1. Make sure there is nothing to fall or tip over.
2. Carpet slippery floors.
3. Anchor small rugs.
4. Make sure there is good lighting everywhere.
5. Place rubber mat in bathtub.
6. Put handrails where necessary.
7. Don't use furniture as step ladder.
8. Put salt or sand on icy sidewalks.
9. See that children's toys are picked up.

D. Cuts and Scratches:

1. Teach children not to run with or throw sharp objects.
2. Don't leave cuttery or sharp tools laying around.
3. Keep power tools disconnected.
4. Keep playground outside areas clean.

E. Burns

1. Keep handles of pots etc. turned in on kitchen range.
2. Don't put hot dishes or liquids within easy reach of children.
3. Never leave a small child alone in bathtub. He/she may turn on the hot water.
4. Don't hold child in your lap while you pass hot beverages.
5. Don't hold child while you are cooking.
6. Keep matches, cigarette lighters etc. out of the reach of small children.
7. Never throw water on grease or oven fire - smother with salt or soda.

F. Poisoning:

1. Be aware that many articles are potentially toxic. Keep such articles out of the reach of young children, preferably locked.
2. Never leave pills in a handbag or low drawer - children love to RUMMAGE.
3. Never tell a child that a pill is candy or tastes like candy.
4. Never take medicine until you have read the label.

MODULE TEN: GLOSSARY OF FREQUENTLY USED MEDICAL TERMS

OBJECTIVE

The student will become familiar with some of the medical terminology most frequently used.

SECONDARY OBJECTIVES

1. Recognize medical terms on sight.
2. Understand the meaning of the medical terms.
3. Be conversant with some of the medical terms.

GLOSSARY OF FREQUENTLY USED MEDICAL TERMS

A

Abrasion:	Cut - a scraped skin surface, such as a skinned knee which oozes blood.
Acid Stomach:	Upset stomach - burning, knawing feeling in the upper abdomen. Often distress is not continuous and may be caused by gas-producing foods, irritants, too much smoking, over eating. If distress persists it is wise to see a doctor.
Afterbirth:	The placenta and membranes discharged from the uterus a few minutes after the birth of a baby.
Allergy:	An altered capacity to react distressfully to specific substances which cause no symptoms in most people. Symptoms: skin rashes, welts.
Amino Acids:	Building blocks of PROTEIN. There are twenty important amino acids. Eight are considered essential.
Anesthesia:	Loss of feeling. Usually the word refers to the obliteration of pain by anesthetic drugs, with or without loss of consciousness. It can occur from natural processes or accidents: for example, nerve injury.
Antibiotics:	Chemical substances produced by certain cells such as bacteria or yeasts, that are damaging to disease-producing bacteria. Different antibiotics may kill disease germs or prevent them from growing or multiplying.
Antibody:	A protein in the blood modified by contact with a foreign substance, an antigen, so that it exerts a neutralizing action against that substance. Antibodies are the key elements of immunity mechanisms of the body.
Antigen:	Any substance which stimulates the production of ANTIBODIES.
Antihistamines:	A large family of drugs which block some of the effects of histamine, a normal substance in body cells, which plays a part in allergic reactions. Antihistamine drugs are effective in the treatment of hay fever and minor sinusitis.
Aorta:	The great vessel which arches from the top of the heart and passes down through the chest and abdomen. It is the main trunk line of the arterial systems.
Arteriosclerosis:	A thickening and hardening of the walls of the arteries and capillaries leading to loss of their elasticity.
Ataxia:	Loss of muscle coordination.

- Audiometer:** An instrument used in measuring acuity of hearing for sounds of different frequencies. It is an electrical instrument which emits pure tones that can be made louder or fainter.
- Autoclave:** An apparatus for sterilizing instruments by steam under pressure.

B

- Bacteria:** Tiny, colorless, single-celled organisms of the vegetable kingdom. Many bacteria are harmless and even useful to man. Those which cause diseases are pathogenic bacteria.
- Barbituates:** A large family of chemical compounds, most of which can be recognized by a name ending in "al". Properly used under medical direction barbituates are safe and very effective sedatives. The "bad name" of barbituates derives from gross abuse unrelated to medical uses.
- Basal Metabolic Rate:** A baseline of the minimal rate of energy expenditure for maintaining activities such as heart action, breathing and heat production when the body is at rest.
- Bedwetting:** Enuresis
- Benign:** Mild, usually means that a tumor is not cancerous.
- Bile:** A yellowish or brownish fluid continuously manufactured in the liver.
- Biopsy:** Removal of tissue from the body to make a diagnosis.
- Birth Control:** Contraception
- Birth Defects:** Abnormality recognizable at birth. Occurs in about 2% of live births. Causes can be hereditary determined by parental chromosomes, or environmental e.g. accident during pregnancy, or if mother contacted German measles at a critical time of pregnancy.
- Blood tests:** Laboratory tests of blood to obtain information relative to an individual's condition.
- Botulism:** A violent form of food poisoning caused by toxins in improperly canned foods.
- Bowlegs:** Outward bowing of the knee joints common in young children. Usually requires no treatment unless bowing persists after five or six years of age.
- Breath-holding:** Crying of infants and small children so furious that they hold their breath until they turn blue. This is not dangerous - just a temper blow-off.
- Bronchial tree:** The breathing passages which extend from the windpipe. They resemble the branching of tree roots.
- Bronchitis:** Inflammation of the linings of the bronchial tubes.

C

Carbohydrate:	The major source of energy we need for moving, working, acting, living. Carbohydrates are sugar and starches in many complex forms. Cereals, vegetables, fruit are good sources of carbohydrates. Carbohydrates are necessary to burn fats efficiently.
Cardiac:	Pertaining to the heart.
Caries:	Decay of bone, the dentists' word for tooth decay— dental caries .
Castration:	Removal of the testicles or ovaries.
Cataract:	An opacity of the lens of the eye. It is not a foreign substance, but a biochemical change in structure. Increasing age, diabetes, physical injury and chemical injury - are all cited as causes of cataracts.
Catheter:	A hollow tube for insertion through a narrow canal into a cavity to discharge fluids, especially of the urinary bladder.
CCU:	Initials for Coronary Care Unit or Cardiac Care Unit, a hospital unit with staff and apparatus for constant monitoring and care of heart patients.
Centigrade:	(c) A thermometer scale in which water freezes at 0 °C and boils at 100 °C. To convert to Fahrenheit degrees, multiply degrees C by 9/5 and add 32. Average body temperature is 98.6 °F and 37 °C.
Central Nervous System:	(CNS) The brain and nerves of the spinal cord. The system is "central" because all of the nerves of the body, except the cranial nerves which connect directly with the brain, enter or leave the spinal cord.
Cerumen:	Ear wax
Cervicitis:	Inflammation of the neck of the uterus.
Cesarean Section:	Delivery of a baby through an incision in the abdomen and uterus.
Chromosomes:	Threadlike bodies in the nucleus of a cell: They contain GENES and DNA.
Chronic:	Long continued ill health as opposed to acute illness.
Circumcision:	Surgical removal of the foreskin from the penis.
Coagulation Time:	The time it takes for a sample of blood to form a clot.
Color Blindness:	Inability to distinguish colors. Color blindness does not affect keenness of vision or visual acuity.
Coma:	Deep unconsciousness caused by many different conditions including advanced liver and kidney disease, diabetes, poisoning , head blows and strokes.
Comminuted Fracture:	One in which the broken bones are crushed into small pieces.

Compound Fracture:	One in which the broken bone breaks through the skin.
Concussion:	Results from a fall or violent blow to the head. Symptoms: dizziness, stupor, nausea, feeble pulse, cold skin, pallor. The patient may or may not be unconscious.
Congenital:	Conditions or abnormalities present at birth.
Contraception:	Prevention of conception or impregnation.
Contusion:	A bruise.
Corns:	Horny skin thickenings about the size of a pea which usually occur on the toe.
Cretin:	A child born with impaired function of the thyroid gland.
Croup:	Difficult, laborious, raspy breathing and barky coughing of a child.
Cyst:	A normal or abnormal sac with a wall containing liquid or semi-solid material. Frequent sites of cysts that may require surgery are: ovaries, kidneys, skin, and the breast.

D

Deaf-Mutism:	Inability to hear and speak.
D & C:	Dilation and curettage. A minor surgical procedure performed on women. The canal of the uterus is dilated and the lining scraped with a spoon shaped instrument called a curet.
Debridement:	Surgical cleaning of a wound.
Decibel:	The unit of measurement of the loudness of sounds, used in tests of hearing.
Defecation:	Passage of feces; evacuation of the bowel.
Deficiency Diseases:	Diseases caused by some dietary deficiency.
Dehydration:	Drying out of the body, loss of more water than is taken in.
Delirium:	A state of mental confusion, excitement, incoherent talk, restlessness. Associated with high fever, poisonings, infections and metabolic disturbances.
Dermatitis:	Inflammation of the skin- often called eczema. Allergies to various substances are involved.
Diagnosis:	The art and science of identifying a patient's disease, a pre-requisite to treatment.
Diaper Rash:	An ammonia burn resulting from a breakdown of urine.
Diuretic:	An agent which increases the output of urine.

Dysentery:	Inflammation of the colon with severe diarrhea, abdominal cramps, painful rectal straining. Stools may contain blood and mucus.
Dysfunction:	Abnormality or impairment of the normal activities of an organ or bodily process.
Dysmenorrhea:	Painful, difficult menstruation.
Dystrophy:	Degeneration, wasting, abnormal development.

E

Ectopic:	In wrong position, out of place, e.g. ectopic pregnancy where the embryo is implanted in the Fallopian tube.
Eczema:	Inflammation of the skin.
EEG:	An electroencephalogram: a brain wave tracing or record.
EENT:	Eye, Ear, Nose and Throat.
EKG:	An electrocardiogram: a tracing or record of the heart.
Embryo:	The developing human being in the uterus through the third month of pregnancy, after which it is known as a fetus.
Emphysema:	Overinflation of air sacs or surrounding tissues with air which cannot readily escape.
Encephalitis:	Inflammation of the brain.
Enuresis:	Bedwetting, involuntary discharge of urine.
Epidemic:	Rapid spread of a disease attacking large numbers of people in the same locality at the same time.
Etiology:	The study of causes of disease.

F

Fainting:	Brief loss of consciousness due to diminished blood supply to the brain.
Fever:	Abnormally high body temperatures. Fever increases the body's rate of metabolism about 7% for each 1°F of temperature elevation.
Fibroids:	The word commonly refers to muscle and connective tissue tumors of the uterus.
Fissure:	A break or crack in the skin or membrane most frequently in the rectal area.
Fontanel:	The "soft spot" on the top of a baby's head. It fills with bone as the skull grows. It takes about one - two years for the spot to close.
Food Poisoning:	Intestinal infection caused by bacteria or their toxins in food.

Forceps: An instrument with two opposing blades and handles, for grasping, compressing or holding body parts or surgical materials.

G

Gallstones: Stones in the gall bladder that may or may not cause noticeable symptoms.

Gangrene: Death of a tissue due to failure of blood supply to an area.

Gastrectomy: Surgical removal of all or part of the stomach.

Gastritis: Inflammation of the stomach.

Gastroenteritis: Inflammation of the stomach and intestine producing symptoms such as: diarrhea, abdominal cramps, nausea, vomiting, fever.

Gastrointestinal: Pertaining to the stomach and intestines.

Genes: The ultimate units in transmission of hereditary characteristics contained in the chromosomes.

Genitalia: The reproductive organs.

Geriatrics: The medical speciality concerned with the care of old people.

German Measles: A mild viral infection producing a pink rash which spreads all over the body.

Gestation: Pregnancy

G.I.: Gastro-intestinal

G.I. Series: X-ray films and fluroscopic observations of the gastro-intestinal tract.

Gingiva: The gum. Gingivitis - inflammation of the gums.

Gland: A cell or organ which makes and releases hormones or other substances used in the body.

Glucose Tolerance Test: A test for early diabetes and other metabolic disorders. It measures the patients' ability to reduce blood sugar levels at a normal rate.

Goiter: Enlargement of the thyroid gland. There are several types of goiters.

Gonads: The primary sex glands, ovaries or testes.

Gonorrhea: The most common venereal disease. Recovery from gonorrhea does not give significant future immunity; re-infection is frequent.

Grand mal: Severe epileptic seizure - convulsions, loss of consciousness, jerking and stiffening of the body.

Groin: The lowest part of the abdomen where it joins the leg.

G.U.: Genitourinary

Gynecologist: A physician who specializes in diseases of women.

H

Hallucinogenic drugs:

Chemical agents that produce distortions of the mind.

Hay Fever:

Pollinosis - an allergic reaction to inhaled pollens, characterized by reddened, weepy eyes, runny nose, sneezing.

Heartburn:

Mild to severe burning sensations in the upper abdomen resulting from a backup of the contents of the stomach. Typically occurs often after a heavy meal consisting of fatty foods. Although uncomfortable, heartburn is not a serious condition and does not necessarily require treatment.

Heart Murmurs:

Various sorts of swishing sounds murmured by the heart. Murmurs do not necessarily indicate serious disease. Some are congenital, some are acquired. The meaning of murmurs must be interpreted by a physician.

Hematocrit:

The percentage of red blood cells in whole blood, by volume.

Hematoma:

A swelling filled with blood clots to form a solid mass.

Hemiplegia:

Paralysis of one side of the body due to a clot or rupture of a brain artery.

Hemoglobin:

The coloring matter of red blood cells.

Hemophilia:

Bleeder's disease: a defect in clotting ability of the blood. Caused by varying degrees of deficiency of a constituent of blood plasma which has an essential role in the process of blood coagulation. The substance is called AHF - anti-hemophilic factor.

Hemorrhage:

Bleeding. The only normal form of bleeding is menstruation. Otherwise, bleeding is a sign that something is wrong.

Hemorrhoids:

(piles) Dilated, overstretched, varicose veins in and around the rectal opening.

Hepatitis:

Virus-caused inflammation of the liver. There are also non-viral forms e.g. anebic, alcoholic, toxic and syphilitic.

Hermaphrodite:

A person with the sex organs of both sexes. True hermaphrodites are rare.

Hernia:

Protrusion of an organ or part of an organ through a weak spot in tissues which normally contain it. The most common type is inguinal hernia.

Hodgkin's Disease:

Malignancy of the lymph nodes. The disease is curable.

Huntington's
Chorea:

A rare hereditary disease appearing in the middle life or later. There is progressive deterioration of the nervous system. Symptoms: jerky, involuntary movements of the arms, legs, face, personality changes, speech defects, difficulties of walking and swallowing. If members of the family in which the disease has appeared are carriers of the defective gene, they should forego having children. Half of their children will have the disease. The disease is not curable.

Hydrocephalus:

Water on the brain - abnormal amounts of CEREBROSPINAL FLUID in brain cavities, exerting destructive pressure on brain substance.

Hydrophobia:

A common word for RABIES. The literal meaning of the word is fear of water.

Hymen:

A membranous partition which partially blocks the external orifice of the vaginal vagina.

Hypertension:

Abnormally high blood pressure.

Hypodermic:

Under the skin, usually refers to hypodermic injection, or the needle, or the "shot" itself.

Hypoglycemia:

Deficiency of sugar in the blood.

Hypotension:

Low blood pressure.

Hypothyroidism:

Deficiency of thyroid hormone, leading to a slowdown of mental and physical processes. If it occurs in an infant before birth, it is known as cretinism.

Hysterectomy:

Surgical removal of the uterus.

I

Identical twins:

Twins, always of the same sex and have the same heredity, developing from a single fertilized egg.

Impotence:

Incapacity of the male to have a penile erection and perform the sexual act.

Indigestion:

A lay term for abdominal distress with such symptoms as heart burn, bloating, gas, cramping.

Infertility.

Inability to have children.

Influenza:

An acute, highly contagious viral infection tending to occur in epidemics.

Inoculation:

Introduction of a disease agent into the body to produce a very mild form of disease giving immunity.

Insulin:	A hormone produced by cells of the pancreas gland, essential for metabolism. Insulin is used in treatment of diabetes and must be given by injection.
Intern:	A graduate of medical school who serves in a hospital for a year or more preparatory to his being licensed to practice medicine.
Internist:	A specialist in internal medicine - in diseases of the internal organs.
Intrauterine Contraceptive Devices:	IUD, IUDC. Flexible devices inserted by physician into the uterus for purpose of preventing pregnancy.
Intravenous:	(I.V.) Into the vein e.g. intravenous feedings.
Iron:	The essential mineral of hemoglobin.

J

Jaundice:	Yellowish discoloration of skin and tissues by bile pigments in the blood.
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K

Knee Jerk:	The patellar reflex; sudden jerking forward of the lower leg when tapped below the kneecap. A test of integrity of nerves.
Knock-knees:	Inward bending of the knees at the joint : in young children it usually corrects itself.
Kwashiorkor:	A protein deficiency. It occurs most often in children in sub-tropical climates whose diet consists mainly of cereal. Affected children have pot bellies, muscular wasting, growth failures

L

Labor:	Childbirth. There are three stages: dilation of the cervix, expulsion of the baby, expulsion of the placenta (after birth).
Lactation:	Secretion of milk.
Laryngitis:	Inflammation of the larynx (voice box) - usually associated with a cold. The throat is dry, swallowing is difficult, speech is affected.
Lead Poisoning:	Intoxication from absorption of lead into the body. Symptoms: abdominal pain, constipation, pallor, drowsiness, mental confusion.
Leprosy:	A chronic disease, often very painful, which inflicts cruel deformities and mutilations, caused by bacteria. The disease affects the skin and nerve tissues.
Leukemia:	Malignant disease of blood-forming organs, sometimes called cancer of the blood.

Little's Disease:	Cerebral palsy of children affecting both sides of the body.
LSD:	Lysergic acid diethylamide : dangerous drug.
LPN:	Licensed Practical Nurse.
Malaria:	An infectious disease characterized by chills and fever. Caused by parasites transmitted to man by bites of mosquitoes.
Malaise:	Listlessness, tiredness, irritability, depression, general feeling of illness and being under the weather.
Malignant:	Life-threatening, the usual medical meaning is "cancerous".
Mastectomy:	Surgical removal of the breast usually because of cancer.
Measles (rubeola):	An infectious disease caused by viruses. Although most children recover from the disease, it could present serious after-effects, and could be fatal. Possible after-effects are ENCEPHALITIS and mental retardation. Immunization vaccines are easily available. All children should be immunized.
Medicaid:	A medical assistance program that pays medical care costs for people with low incomes.
Medicare:	Health insurance, administered by the Social Security Administration, for all U.S. citizens who have passed their 65th birthday.
Melanin:	A yellow to black pigment which is a factor in skin color.
Meningitis:	Inflammation of the covering membranes of the brain or spinal cord. Symptoms: fever, headache, stiff neck, a red rash. The disease is transmitted by person to person contact.
Menopause:	Cessation of menses : it marks the end of a woman's reproductive years. Average age of onset is forty-eight to fifty.
Metabolism:	The sum total of all physical and chemical activities by which life processes are organized and maintained. It is the breakdown and buildup of complex substances by body cells, assimilation of nutrients, and transformations which make energy available to the living organism.
Minimal Brain Damage:	The term used to describe children who appear to lag in development, are hyperactive or listless, and exhibit socially inappropriate behaviors.
Miscarriage:	Expulsion of the fetus before it can live.
Mongolism:	A congenital abnormality: mongoloid babies have upward slanting eyes, broad faces, flattened skull, short hands, feet and trunk, stubby nose. The mental capacity of most mongoloids is three to seven years. Life expectancy is not great.
Morning Sickness:	The simplest form of nausea in pregnancy: the symptoms usually persist for two to three weeks.

- Myelitis: Inflammation of the spinal cord or bone marrow. Poliomyelitis is inflammation of grey matter of the cord.
- Miringitis: Inflammation of the eardrum.
- Myringotomy: Incision of the ear drum to relieve pressure of pus and fluids behind it.

N

- Narcissism: Self-love, undue admiration of one's own body. Self-admiration at a fixed level is appropriate for infants but not adults.
- Neonatal: Newborn, the first two or three days of life.
- Nephrectomy: Surgical removal of the kidney.
- Nephritis: Inflammation of the kidney.

O

- Obese: Overweight
- Ophthalmologist: A doctor of medicine specializing in medical and surgical care of the eyes.
- Optician: A skilled technician who fills the prescription of an ophthalmologist or optometrist for glasses or contact lenses.
- Optometrist: An expert qualified to fit and prescribe glasses and contact lenses and give non-medical care of the eyes.
- Oral Contraceptives: "The pill" taken by women by mouth to prevent pregnancy.
- Orgasm: The climax of the sexual act, terminating in ejaculation of semen in the male and release of tension in the female.
- Orthodontics: The branch of dental science concerned with prevention and correction of irregularities of the teeth and jaws.
- Orthopedics: The surgical and medical specialty concerned with correction of deformities, diseases, accidents and disorders of the limbs, joints, muscles, tendons bones.
- Ossification: The process of forming bone.
- Osteomyelitis: Infection of bone and marrow due to growth of germs within the bone.
- Otorhinolaryngologist: A medical specialist in diseases of the ear, nose and throat.
- Ovariectomy: Surgical removal of one or both ovaries.

Ovulation:	Release of a mature egg cell from the ovary.
Ovum:	The female reproductive cell.
Outpatient:	A patient who comes to a hospital for treatment but does not stay overnight at the hospital.

P

Pacemaker:	Small knot of tissue in the right auricle of the heart which triggers the heart beat.
Papanicolaou Smear (pap smear):	A screening test for cancer of the cervix and uterus.
Paranoia:	A form of mental illness characterized by suspiciousness, delusions, feelings of being persecuted, spied upon, . endangered.
Paraplegia:	Paralysis of both legs, usually due to injury of the spinal cord.
Paratyphoid:	An acute infectious disease which resembles typhoid fever but is less severe.
Parkinson's disease:	A chronic, progressive disease. Symptoms: tremor, stiffness, slowness of movement. Cause: disturbance of a small center at the base of the brain.
Pathogenic:	Having the capacity to produce disease.
Pathology:	The science and study of the nature of disease- its processes, effects, causes, symptoms, etc. It does not mean disease, rather the study of disease.
Peptic ulcer:	An ulcer associated with the digestive action of acid juices. It may be located in the stomach or duodenum.
Petit Mal:	A mild form of epileptic attack, consisting of sudden loss of consciousness and lasting for a few seconds.
pH:	A scale of the acidity or alkalinity of substances. The neutral point is pH7. Below 7, acidity increases, above 7 alkalinity increases.
Phlebitis:	Inflammation of the walls of a vein, which may lead to the formation of a clot.
Phobia:	An abnormal fear - there are various kinds of phobias.
Pigeon Toe:	Inward turning of the feet and toes when walking. Children in the early stages of walking are usually pigeon-toed, but they outgrow it.
Plasma:	The fluid part of the blood, minus the blood cells and clotting elements.

Platelets:	Tiny, colorless elements of the blood that help to start blood clotting. They are manufactured in the bone marrow.
Pneumonia:	Inflammation of the lungs caused by various organisms. Symptoms are fever, chills and coughs. Treatment: antibiotics, especially tetracycline.
Post partum:	After childbirth.
Premature birth:	An infant born before the nine month gestation period is over.
Prenatal:	Before birth.
Prognosis:	A doctor's forecast of the course and duration of an illness based on the best information available to make a judgement.
Psychosomatic disease:	Disability, with or without physical causes, in which the patient's emotions play an important part in inciting, worsening, or continuing the disability.
Psychosis:	Serious mental illness usually requiring treatment in a hospital.

Q

Q. i.d.:	Four times a day.
Quadraplegia:	Paralysis of both arms and legs.

R

Rabbit Test:	A biologic test for determining pregnancy.
Rabies:	A lethal disease, caused by viruses, which affects the brain and nervous tissue. The virus is transmitted to man by the bite of an infected animal. The disease is fatal - it has an incubation period of a month to a year. Prompt treatment - daily injection of rabies vaccine for two weeks - usually prevents rabies from taking hold. Treatment is painful.
Radiologist:	A physician who specializes in the making and interpretation of X-ray studies.
Radiotherapy:	Treatment of disease by X-rays, radium, radiosotopes, and other forms of ionizing radiation.
Respirator:	A "iron lung" - a mechanical device for patients whose breathing muscles are paralyzed by disease or injury.
Resuscitation:	Artificial respiration applied to a person threatened with death by asphyxia.

Rheumatism:	A general term for distressing, painful, disabling conditions affecting the joints.
Rhinitis:	Inflammation of the mucous membrane of the nose.
Rhinorrhea:	Runny nose.
Rhythm Method:	A method of avoiding pregnancy by not engaging in sexual intercourse during the fertile phase of the menstrual cycle.
Rickets:	A vitamin deficiency disease of infants, resulting from insufficient supply of vitamin D.
R.N.:	Registered Nurse.

S

Salk vaccine:	A killed-virus vaccine establishing immunity to polio.
Salmonella:	A family of bacteria which cause gastrointestinal infections.
Sclerosis:	Hardening of tissue.
Semen:	The whitish secretion containing SPERMATOZOA which is ejaculated by the male during orgasm.
Sickle Cell Anemia	An hereditary abnormality of hemoglobin. Crises' marked by fever and attack of pain.
Snelling Chart:	The familiar eye test chart consisting of block letters in diminishing sizes.
Spermatozoa:	Male sperm cell.
Sphincter:	A muscle which surrounds and controls opening and closing of a natural orifice e.g. the anal sphincter.
Spinal Tap:	Withdrawal of cerebrospinal fluid through a needle. Used in diagnosis of such diseases as meningitis and polio.
Sprain:	Tearing and laceration of ligaments that hold bones together at a joint.
Sterilization:	Any procedure which leaves a man or women incapable of having children. Tubal ligation for the female, vasectomy for the male.
Stethoscope:	An instrument which conducts bodily sounds, especially those of the heart.
Stool:	Feces
Syndrome:	A set of symptoms which occur together and collectively characterize a disease.
Term:	The end of the normal period of gestation or pregnancy when birth occurs.

Tetanus:	A grave, often fatal infection caused by toxins or tetanus organisms which get into the body by penetrating deep wounds. The disease is prevented by harmless tetanus shots.
Therapy:	Treatment of disease.
Threadworms:	Roundworms which in larval form can enter the body through the skin, usually of the feet, and go to the intestines. Symptoms: pain in the lower part of the stomach, diarrhea.
Thrombosis:	Formation of a clot in a blood vessel.
Tics:	Habit spasms : quick, repetitive movements of certain muscle groups.
T.i.d.:	Three times a day.
Tolerance:	Ability to withstand abnormally large doses of a drug, induced by its continual use.
Toxemia:	A poisoned condition due to absorption into the blood of toxic substance produced by bacteria or body cells, but there is no bacteria in the blood.
Tranquilizers:	A popular, non-medical term for a variety of drugs which depress the central nervous system to produce calming, sedative effects, but which do not dull consciousness or induce sleep.
Transplantation:	Surgical techniques for transplanting an organ from one person to another.
Trauma:	Injury, wound
Trichinosis:	A parasitic disease due to the ingestion of encysted larvae of worms present in raw or undercooked pork.
Trichomoniasis:	A common investation of the vagina. It produces vaginal irritation and a thin, white, offensive discharge.
Tubal Pregnancy:	Implantation of a fertilized egg in the walls of the Fallopian tube instead of in the uterus.

U

Umbilical cord:	The long flexible tube which is attached to the placenta at one end and to the abdomen of the fetus on the other.
Undescended Testes:	One or both testes fail to descend from the abdomen into the scrotum.
Urinalysis:	Inspection and chemical analysis of the urine.
Urologist:	A doctor who specialized in diseases of the urinary tract.

V

Vaccine:	Bacterial or viral material for inoculation against a disease.
Vaginitis:	Inflammation of the vagina, characterized by discharge and discomfort.
Valve:	A structure that prevents backflow of fluids e.g. valves in the heart.
Varicose veins:	Swollen, dilated, knotted, tortuous veins. The sites mostly affected are the legs and anus.
VDRL test:	A screening test for syphilis.
Viruses:	Molecules that cause diseases:

W

Warts:	Harmless but unsightly small growths from the skin. They are caused by viruses, are contagious, and the sufferer can re-innoculate themselves repeatedly.
Wassermann Test:	The original blood test for syphilis.
W.B.C.:	White blood cell count.
Whooping cough (pertussis):	A serious but preventable childhood disease, especially dangerous and sometimes fatal in infants. The vaccine is readily available.

X

X-Chromosome:	The female sex-determining chromosome: females have two of them, males only one.
X-rays:	Electromagnetic radiation of shorter wavelength than visible light. X-rays can penetrate solid substances, produce shadows of structures of different densities on film.

Y

Y-Chromosome:	The male sex-determining chromosome.
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Z

Zygote:	The fertilized egg cell before it begins to divide.
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CHAPTER FOUR
EMOTIONAL DEVELOPMENT

CHAPTER IV

EMOTIONAL DEVELOPMENT

INTRODUCTION

Emotion is the essence of the human being. What we feel about ourselves, our family, our friends, our teachers, our school, and the society in general permeates all aspects of our lives. Research has repeatedly shown that the way an individual feels about the self literally dictates the way the individual functions. If children feel good about themselves they feel secure, worthwhile and loved and are able to develop their potential: to grow and to learn.

These feelings about the self are often referred to as self-concept. Self-concept is the perception an individual has about the self as a competent person of worth. It is dependent, in large measure, upon how the individual evaluates himself on the competencies that he/she considers important (Coopersmith, 1967), and is developed through diverse experiences through interactions with other people, and emerges only in the presence of other human beings (Jahoda, 1958).

Since self-concept - these feelings about the self - is developed through interactions with other human beings, it stands to reason that positive self-concept can only be developed through positive, supportive interactions with other people.

Positive self-concept development or healthy emotional development begins at birth and continues throughout life. To facilitate healthy emotional development of children, the adults who have the responsibility for rearing children should make every effort to ensure that children have positive, supportive experiences.

Remember - children are the world's most valuable resource and its best hope for the future. J. F. Kennedy.

REFERENCES:

- Coopersmith, S. The antecedents of self-esteem. California: W.H. Freeman & Co., 1967.
- Jahoda, M.. Current concepts of positive mental health. New York: Basic Books, 1958.

OBJECTIVES

1. Understand the term healthy emotional development.
2. Differentiate between emotionally healthy behaviors and those behaviors that are indicative of an emotional problem.
3. Have a clear understanding of the commonly used terms.
4. Understand the theory underlying the supportive framework as well as the practical application of the strategies and techniques of the supportive framework.
5. Understand the ego functions and how they relate to healthy emotional growth.
6. Apply the knowledge gained as part of objectives one through five in everyday interactions with children.
7. Know a variety of referral sources.

OBJECTIVE ONE

Understand the term healthy emotional development.

A. CONTENT

Healthy emotional development is a state of being through which an individual is able to cope with everyday life experiences in a socially acceptable fashion. According to Haring (1974) an emotionally healthy individual possesses six main traits:

1. The ability to function independently.
2. The ability to develop lasting, positive, interpersonal relationships.
3. The ability to have an accurate perception of reality.
4. The ability to be productive in proportion to the environment.
5. The ability to organize thoughts and actions.
6. The ability to master developmental tasks.

B. METHODS OF INSTRUCTION

The basic method of teaching is an analytical discussion. Each specific aspect of the definition should be thoroughly discussed. Analytical discussion includes four basic steps.

1. Verbally dissect the material.
2. Relate the concepts involved in practical experiences.
3. Provide some practical experiences through "role play" situations and classroom practicum. For example, have students observe and record behaviors of an individual child in an attempt to see if the behaviors observed indicate that the child possesses the six main traits of an emotionally healthy individual.
4. Evaluate, through formal or informal tests and observations, to see if the student has internalized and can apply the concepts involved.

C. RESOURCES

1. Consultant psychiatrist or clinical psychologist.

2. Books:

Fraiberg, Selma. The magic years. New York: Charles Scribner's Sons, 1959.

Haring, Norris G. Behavior of exceptional children: An introduction to special education Columbus, Ohio: Charles E. Merrill Publishing Co., 1974.

Redl, Fritz. When we deal with children New York Free Press, 1966.

Erikson, Erik. Childhood and Society New York: The Norton Press, 1963.

3. Audio-visual Aids:

- a. Film Strip Set: "The Development of Feelings in Children.

- b. Individual Film Strips: "How Feelings Grow", "Expressing Feelings"
Produced by Parents Magazine Films Inc.

Film Strip Set: "The Child's Relationship With the Family"

Individual Film Strip: "How a Child Sees Himself"
Produced by Parents Magazine Films Inc.

D. EVALUATION

1. Written examination - pre and post test
2. Self-evaluation
3. Direct observations of student by trainer in practicum situations.
4. Follow-up discussions with trainer and/or consultant psychiatrist.

OBJECTIVE TWO

Differentiate between emotionally healthy behaviors and those behaviors that are indicative of an emotional problem.

A. CONTENT

The following are some examples of normal and abnormal behaviors. These are just a few examples and are not intended to cover the broad spectrum of human behavior, and normality and abnormality. In addition, it must be clearly understood that the behaviors listed as examples of emotionally unhealthy behavior must occur repeatedly to be indicative of an emotional problem. Behaviors are symptomatic and are not a diagnosis. Diagnoses must be made by a psychiatrist or psychologist.

AGE

EMOTIONALLY HEALTHY
BEHAVIOREMOTIONALLY UNHEALTHY
BEHAVIOR

The Pre-School Years

0 - 3 months

Dependent on adult for satisfaction of all physical needs. Sucking reflexes developing. Cries to indicate his needs. Indication that child is beginning to impose their wants on the world, and to respond to the world. Reacts positively to comforts and satisfaction.

Excessive crying even when all physical needs appear to be met.

Lethargy: no crying or activity.

3 - 7 months

Still dependent for need satisfaction. Becomes aware of environment as evidenced by eyes following objects and reaching and grasping attempts. Becomes aware of relationship with caretaker, but still does not perceive him/her as separate individual. Begins to respond to people and things by smiling, cooing.

Child's inability to respond to the environment.

8 - 13 months

Child recognizes caretaker and sees her/him as a separate entity. Expresses anxiety with strangers: not a good time for change. Still very dependent. Becoming aware of body: evidenced by child exploring his body - putting foot in mouth.

Willing to go with any adults: reaches out to strangers. Overly friendly, shows no fear of strangers. Lethargic: the child is inactive, no attempt to explore his body.

14 - 19 months

Child very active; often described as getting into everything: needs restrictions and outlets for energy. The "No-no" stage. Child says "no" because he has heard it so often. Beginning to want to do things for self. Curious and very explorative. Temper tantrums begin.

The inverse of these behaviors: lethargy, quietness, inactivity, etc. Total dependence on adults. Excessive temper tantrums.

AGE	EMOTIONALLY HEALTHY BEHAVIOR	EMOTIONALLY UNHEALTHY BEHAVIOR
20-24 months	Less dependent on caretaker but constantly comes back for reassurance - referred to as the "refueling stage." Sometimes clings to caretaker. Manipulative stage - child is constantly testing the environment and limits; consistency is very important. Child is usually ready to be toilet trained; able to control sphincter muscles. Begins to imitate adult roles need encouragement.	Total dependency or total independency. Completely obedient - no attempt to test limits.
25-36 months	More independent, not an easy member of social group. Jealous of peers and siblings. Very selfish, unwilling to share; enjoys repetition - may sing jingle bells all year long. Very orderly. Involved with monsters - magical thinking. Concerned with body loss and body damage. Rigid and inflexible. Temper tantrums leveling off. Very stubborn.	If the child has not acquired a sense of trust then emotional problems will develop. If any of the behaviors mentioned under healthy emotional development are exhibited in the extreme they may be indicative of an emotional problem.
3-3½ years	Child feels secure;; available to share; uses "we" instead of always "my." Forms better social relationships. Likes to make friends Can tolerate changes in routine. Frustration threshold increasing. Stage of equilibrium- temper tantrums on the decrease.	If the child is still manifesting behaviors that are indicative of previous stages, an emotional problem or slow emotional development may be indicated. Refusal to be toilet trained is indicative of a problem, even though bedwetting may still be common.

AGE

EMOTIONALLY HEALTHY
BEHAVIOREMOTIONALLY UNHEALTHY
BEHAVIOR

3½ - 4 years

Independent - wants to do things for himself. Stage of disequilibrium: temper tantrums once again on the increase. Insecure: demanding of adults, clings to caretaker. Tension outlets: bites nails, sucks thumb excessively, masturbation. Social relationships difficult to make: jealous of others, uncertain group member. Extremes in behavior - shy one minute, out of hand the next. Wants attention exclusively. Stuttering common: even when child has never stuttered before.

Excessive crying and whining. Extremely questioning of caretaker: will constantly ask "Do you love me?" Extremely demanding of adults. Insecure with friends and adults, demands all the attention.

4 - 4½ years

Out of bounds; hits, screams, kicks, fights, throws, breaks things, runs away; loud silly laughter alternates with fits of rage; often uses profanity. Child resists adult authority, thrives on being defiant. Very imaginative: makes up long stories - line between fact and fiction thin; indulges in exaggeration. Clear limits must be set.

Overly involved in fantasy. Constantly plays superhero television roles. Quietness and conformity are problem behaviors at this stage.

4½ - 5 years

Is able to differentiate between real and imaginary. Self-motivated; can start and complete task without adults assistance. Interested in details; great discussers. Good threshold for frustration. Desire for realism important; child may ask questions that shock adults and demand to know right answers, e.g. questions about sex, birth and death.

Over involvement with fantasy roles. Total dependency on adults. Low frustration threshold. Nonverbal, overly quiet.

5 - 6 years

Reliable, stable, well-adjusted. Secure; can form good social relationships, peers are important, good group members. Caretaker in the center of his world; likes to do things for self; likes to be guided. Satisfied with self. Not very explorative, likes to stick with things that he/she knows: will not attempt anything that he/she can not do.

Inverse of all of these behaviors, if they are evidenced in the extreme, are problematic.

AGE	EMOTIONALLY HEALTHY BEHAVIOR	EMOTIONALLY UNHEALTHY BEHAVIOR
The Middle Years: 6 - 10 years.		
6 years	Caretaker is still primary figure. Internal conflict between independence at school and dependence on caretaker. Competitive, desire to achieve. Playful and active. Stage of name calling begins. Inconsistent in level of maturity. Group activities among boys/ girls are popular.	Withdrawal, tests limits, combative: picks fights with peers; cries easily. School phobia: refuses to attend school. Bullishness: picks fights with younger and physically smaller children. Clowning: an attempt to get attention. Bribery and flattery in an attempt to find friends.
7 years	Dependent on approval of adults. Interest of boys/girls diverging. Talkative, prone to exaggerate, verbal fighting versus physical. Cautious and self critical. Concerned with right and wrong.	
8 years	More dependent on caretaker again. New awareness of individual differences. Death phobia, preoccupation with death.	Pseudo - adult: overly friendly with adults; constantly does favors for teachers; listens constantly to adult conversations; uses adult language and colloquialisms.
9 - 10 years	Responsible, dependable, strong sense of right and wrong. Values come into focus. Individual differences very distinct. Capable of making plans must do well. Progress in sex development.	

AGE	EMOTIONALLY UNHEALTHY BEHAVIOR	EMOTIONALLY UNHEALTHY BEHAVIOR
Pre-Adolescence 10 - 12 years	Teasing, Antagonism between boys and girls, restlessness; laziness. Value opinion of own group above adults. Rebellious, uncooperative, self-conscious about physical changes. Intense curiosity for sexual anatomy.	
Adolescence 11 - 17 years	Know it all attitude; regression to early childhood behaviors: demanding attention from adults. Over-sensitive. Self-pity, strong identification with admired adult: crushes on stars, teachers. Camaraderie with peer group as opposed to parent interest. Privacy is of prime importance. Tends not to confide in parents. Influenced by peer groups: high interest in physical attractiveness.	Flamboyant: attempts to use body in sexually seductive ways.

B. METHODS OF INSTRUCTION

1. Didactic workshop sessions in which age appropriate and inappropriate behaviors are thoroughly discussed are a necessity. Emphasis should be placed on the sporadicity and unevenness of emotional development. Special attention should be paid to the fact that some "so-called" negative behaviors are emotionally healthy behaviors at certain ages.
2. Synonymous with the didactic workshop sessions, practical experiences are provided. The student is given the opportunity to carefully observe children of all ages.
3. The student is required to make anecdotal records during observations.
4. Immediately following each observation period, time is allotted for discussion. Behaviors observed by the student are discussed, explained and interpreted. Ideally, these discussions should be led by a child psychiatrist or clinical psychologist.

C. RESOURCES

1. Consultant psychiatrist or psychologist.

2. Books:

Jenkins, G and Schacter, H. These are your Children, (4th ed.). Illinois: Scott, Foresman and Co., 1975;

Morse, W. C. and Wings, M. C. Psychology and teaching. Illinois : Scott, Foresman & Co., 1969.

Mussen, P., Conger, J. and Kagan, J. Child development and personality. New York, N. Y.: Harper and Row Publishers, 1969.

Weiner, I. B. and Elkind, D. Child development: A core approach. New York: John Wiley & Sons, Inc., 1972.

3. Publications:

Murphy, Lois and Leeper, Ethel. Caring for children series one through eight. Washington, D. C.: U. S. Dept. of Health, Education and Welfare, 1974/1976.

Responding to Individual Needs in Head Start: Part 1: Working with the Individual Child. Government Printing Office, Washington, D.C. Publication No.: (OHD) 76-31075.

4. Flyers:

Vallis, A. "Emotional Development - Birth to Six Years of Age." Available through the National Child Day Care Association, Wash., D. C.

5. Audio-Visual Aids:

Film Strip Series: The Understanding Early Childhood Series

Set A: "The Child's Relationship with the Family."

1. "How a Child Sees Himself."
2. "Learning from our Children."

Set B: "The Development of Feelings in Children."

1. "How Feelings Grow."
2. "Expressing Feelings."

Film Strip Series: Children With Handicaps: Behavioral and Emotional Disorders.

Film strips noted above are produced and published by the Parent's Magazine Films Inc., Parent's Magazine Enterprises, Inc., Vanderbilt Avenue, New York, N. Y. 10017

D. EVALUATION

1. Written Evaluations: Pre and post tests.
2. Observations of students in practicum experiences.
3. Self-evaluations.

OBJECTIVE THREE

Demonstrate that he/she has a clear understanding of the commonly used terms.

A. CONTENT

It is a well known fact that every discipline uses its' own jargon. The outcome of any paraprofessional training effort should be to provide the paraprofessionals with skills which enable them to work with professionals. If the paraprofessional is to function effectively as an integral part of the staff, it is imperative that he/she is familiar with at least the most frequently used terms of the specific discipline.

The following is a glossary of some of the terms frequently used in the area of mental health. These are representative of only a few of the most commonly used terms. They are not intended to give the reader the impression that the subject is covered in its entirety. The primary reference source used for this glossary is Freedman, A., Kaplan, H., and Saddock, B (eds.) Comprehensive Textbook of Psychiatry: I/II - Baltimore, Md: Williams and Wilkins Co., 1972.

GLOSSARY OF TERMS USED IN MENTAL HEALTH

A

- Abnormal:** Deviating from the average or normal. Demonstrating verbal or non verbal behaviors different from those expected at certain age levels.
- Acting Out:** Inappropriate behavior that is indicative of the inability to cope with a stressful situation. For example, on the first day of school a child is afraid to go. He is unable to verbalize or to counteract this fear. Instead he feigns illness, throws temper tantrums, picks fights with his siblings, is rude to his parents etc.
- Adjustment Reaction:** A transient disorder that represents an acute reaction to a traumatic or stressful experience.
- Affect:** An emotional feeling attached to an object, idea or thought. The term includes both the feeling and the external behavior that are manifested as a result of the feelings.
- Aggression:** Forceful verbal or physical behavior. Usually an unprovoked attack on self or others caused by rage, anger or hostility. Terms used interchangeably with aggression are aggressive and aggressive behavior.
- Anal phase:** The second stage in normal psychosexual development. It occurs when the child is between the ages of 1 and 3. During this period the child's activities, interests and concerns are centered around the anal and rectal areas. During this phase the child is increasingly preoccupied with bowel function and control.
- Anxiety:** Unpleasant affective reaction to a future situation or event. The reaction produces psychophysiological changes. The physiological changes include disturbed breathing, increased heart rate, trembling and sweating. The psychological changes include prolonged tension, feelings of danger, feeling powerless and out of control of the situation.
- Attention Span:** The length of time that an individual is able to devote to a task. An individual's attention span increases with age. An infant has a shorter attention span than a toddler and so on.
- Antisocial Behaviors:** Behaviors that are considered inappropriate by societal standards. Examples are frequent temper tantrums at age 6, fighting and cursing. Often characterized by the inability to develop and maintain positive interpersonal relationships : inability to get along with others.

- Autism:** A form of mental illness. In children, it is considered the first manifestation of childhood schizophrenia. An autistic infant cannot make contact with his environment. The child does not respond to environmental stimuli : being hugged, touched, cuddled, to noise or to pain. The autistic child demonstrates bizarre motor patterns : head banging, flapping of hands, twisting of fingers, body rocking and swaying.
- Behavior Disorder:** Disorders that occur in childhood and adolescence that are more serious and stable than transient situational disturbances, such as adjustment reactions, but less serious than psychosis and neurosis. The symptoms include : overactivity, inattentiveness, shyness, feelings of rejection, over-aggressiveness, timidity and delinquency. Six most frequently recognized behavior disorders are : hyperkinetic reaction, withdrawal, overanxious reaction, runaway reaction, overaggressive reaction, and delinquency.
- Blocking:** Involuntary cessation or interruption of thought and/or speech processes caused by unconscious emotional factors.
- Brakes:** See holding brakes.
- Castration Anxiety:** Fear of losing or injuring genitalia. Normal concern in children between the ages of three to five.
- Central Nervous System:** Usually referred to as CNS. It includes the brain and the spinal cord.
- Child Abuse:** Any form of maltreatment of a child usually by an adult. There are three most common forms of child abuse. These are: physical abuse or injuring the child by beating, burning, cuffing, physically restraining with ropes, etc; Verbal abuse or demeaning or belittling the child with words or using profanity (cursing) when disciplining the child; Sexual abuse or an adult having sexual relations with a child. Rape, incest, prostitution are all included under sexual abuse.
- Confidentiality:** Aspect of professional ethics in which the staff person is bound to hold secret all information given them by the patient/parent. This information cannot be shared unless written permission is obtained from patient/parent. Information is shared among staff for the sole purpose of providing the best possible treatment for the patient. This information must be kept within the staff and must not be discussed with individuals who are not directly involved in the treatment of the patient.
- Congenital:** This term refers to conditions that are present at birth. Hereditary conditions and those resulting from the pre-natal environment or the birth process itself are included.

- Contagion:** Behavior negative or positive, but more often noticed when the behavior is negative, is initially being exhibited by one or more children. However, because of the lowered psychological level of the group, the behavior spreads through the group.
- Coping Mechanisms:** Conscious and unconscious way of dealing with stressful or difficult situations.
- Coping Skills:** Method developed by an individual or capacity of the individual to deal with or overcome a psychological or social problem.
- Defense Mechanism:** An unconscious process that is protective in nature. It is used to relieve the anxiety and conflict that arise from one's impulsive reaction to a given situation.
- Defensive Emotion:** Strong feeling that serves as a cover up for a less acceptable feeling. For example, a patient is afraid of his upcoming surgery. However, he expresses anger at those around him. In this instance, anger is, usually unconsciously, more acceptable to the patient than expressing the fear that his anger covers up. In this instance, anger is a defensive emotion.
- Dependency:** The need to rely on another for psychological and/or physical support. Reflects the need for security, love, protection and mothering.
- Depression:** A state of being characterized by moodiness, low self-esteem, self-reproach, and withdrawal. In extreme cases of depression the person is often suicidal.
- Distortion:** Misrepresentation of reality. This is usually unconscious and the patient honestly believes that his interpretations are valid.
- Drooling:** Uncontrollable salivation.
- Ego:** That part of the mental processes that enable a person to decide how to regulate their behavior.
- Ego Functions:** The twelve (12) basic processes that an individual acquires as the ego develops. These are described in detail under emotional objectives no. 5.

Electra Complex:	A stage of psychosexual development during which the girls discover the genital differences between boys and girls. The girl sees this difference as inferior, and to make up for her believed inadequacy she "falls in love" with her father. This usually occurs between the ages of three and five.
Emotion:	The complex human system that deals with the ability to feel; feelings.
Emotional Deprivation:	Lack of adequate interpersonal and/or environmental experiences. This usually occurs in the early years and is said to be caused primarily by poor mothering or separation from the mother.
Emotional Support:	Encouragement or hope given to one person by another.
Enuresis	Bed wetting.
Etiology:	The cause of a disease.
Evasion:	The act of not facing up to something. It consists of suppressing an idea, and replacing it with a closely related idea.
Fantasy:	Daydreaming; fabricated mental picture or chain of events. Fantasy sometimes serves as a basis for creativity. In these instances fantasy becomes reality : people actually live out their fantasies.
Fear:	Unpleasurable affect (feeling) consisting of psycho-physiological changes, such as increase in heart rate, trembling, sweating, in response to a threat or danger.
Fixation:	The arrest of development at any stage before complete maturation.
Genital Phase:	The final phase of psychosexual development. It occurs during puberty. In this stage, psychosexual development is so organized that the individual has the capacity for a mature relationship with someone of the opposite sex.
Gestalt Therapy:	Type of therapy, developed by Frederick S. Perls, which focuses on the "here-and-now" rather than past or future experiences.
Guilt:	Feeling (affect) associated with self-reproach and/or need for punishment. It begins with parental disapproval. It is a necessary part of the development of the superego to help an individual do what is considered "right". Special intensity or complete absence of guilt is characteristic of mental problems.
Holding Brakes:	A technique used to physically restrain a child when he has lost control of himself. It involves holding arms and legs in an effort to prevent the child from hurting self or others. The technique is designed to help and not hurt the child. This technique is sometimes used when the teacher/therapist has lost control and needs to regain that control.

- Hyperactivity:** A term used to describe a disturbance found in children that is characterized by overactivity, restlessness, distractability, short attention span. The disturbance is believed to be caused by brain damage, mental retardation, emotional disturbance, or environmental deprivation. It is more common in boys than girls, and recent statistics reveal that 5 to 10 percent of the school population suffer from this disorder. It is also known as hyperkinesis.
- Hyperkinesis:** See hyperactivity.
- Id:** According to Freud, the first stage of the development of the mental processes that deal with instinctual drives that seek gratification.
- Impulse:** Unexpected, instinctive urge motivated by conscious and unconscious feeling over which the person has little or no control.
- Incest:** Sexual activity between members of the family, may be heterosexually or homosexually oriented. Common patterns are father-daughter, mother-son, and between siblings.
- Infantile Autism:** An illness that develops before the age of three. Behavioral symptoms are withdrawal, head banging, rocking, swaying etc. See also autism.
- Infantile Sexuality:** Freudian theory concerning the sexual abilities of infants and children. Encompasses the phases of psychosexual development during the first five years of life. See oral phase, anal phase, phallic phase.
- Inferiority Complex:** Feelings, real or imagined, conscious or unconscious, that an individual is less than someone else. The individual's behavior is determined by this feeling.
- Insight:** Conscious awareness of one's own feelings and behavior.
- Instinct:** A basic, inborn drive. e.g. sucking reflex in the infant.
- Interpersonal Skills:** An individual's ability to relate to others, to express feelings, appropriately, to be socially responsible, to make changes, to work and to create.
- Judgement:** The mental act of comparing or evaluating choices for the purpose of electing a course of action. Judgement is intact if the course of action chosen is consistent with reality; judgement is impaired if the reverse is true.
- Latency Phase:** Stage of psychosexual development - starting at age 5 and continuing through age 12. During this period, there is a cessation of sexual preoccupation, boys and girls are inclined to choose friends and join peer groups of the same sex.

- "Little Man" Syndrome:** Occurs primarily in one parent families where the mother is head of the family. The boy, consciously or unconsciously assumes the role of father. His actions are boisterous, bossy : He always wants to be in charge and take care of.
- Magical Thinking:** A notion that thinking is the same as doing. In infancy this is a normal phase between the ages of 2½ to 3 where the child believes that the world is his/her own; can control it, can make things happen by thinking about it.
- Maladaptive Behavior:** Poorly adjusted or socially unacceptable behavior.
- Maternal Deprivation Syndrome:** Failure of the child to thrive because of inadequate environmental stimulation. This inadequate stimulation is caused by separation from mother very early in life and no adequate substitute mothering is available e.g. children in institutions; prolonged separation from mother or primary caretaker after good mothering has been enjoyed for the first few months of life; inability of the mother to provide proper tactile and emotional stimuli when rearing the child. Maternal deprivation is characterized by retardation of both physical and mental growth and personality and social development.
- Life Space Interviewing:** A technique, developed by Fritz Redl, and used in the treatment of children with emotional problems. It involves dealing with situations as they occur. It provides verbal support for the child in an attempt to help them understand the reasons for their actions and reactions, and the feelings involved. Fritz Redl defines it as giving emotional first aid on the spot. A means of ensuring that the child's psychological development has all the vitamins and nutrients needed for proper growth.
- Mental Health:** Resistance to or absence of mental illness depending primarily on the way a person feels about himself, other people, the world, and his place in the world. Special significance is attached to how an individual feels about earning a living, and how they face up to responsibilities.
- Milieu Therapy:** A method that involves manipulating (setting up) the treatment sit to incorporate aspects of the child's home and school environment in an effort to relieve emotional conflict.
- Minimal Brain Dysfunction:** Usually referred to as MBD. Connotes injury to or malfunctioning of the central nervous system. An MBD child has average or above average intellectual functioning, but has learning and/or behavioral problems. These problems may be characterized by various combinations of deficits in perception, conceptualization, language, memory, and control of attention, impulse or motor function.

Mother Surrogate:	Mother substitute.
Neurosis:	A milder form of mental disorder than psychosis. In neurosis the patient maintains contact with reality. Neurosis is characterized by anxiety, and is often caused by negative self-concepts and feelings of not being adequate.
Oedipus Complex:	A stage of psychosexual development during which boys begin to court his mother almost as a lover would. He expresses his wishes to sleep in her bed, to marry her, and he takes advantage of any opportunity to watch her dress or undress. He competes with siblings for his mothers attention but his primary purpose is to eliminate his father. These feelings usually manifest themselves at the age of three and reach a climax during the fourth or fifth year. This is a normal phase in psychosexual development.
Oral Phase:	The first stage of psychosexual development, lasting through the first eighteen months. During this time sexual activity is centered around the mouth and lips, and is manifested in sucking, biting and chewing.
Organicity:	Usually used when referring to the cause of an illness, mental or learning problems. It means that damage to the central nervous system is a causative factor.
Paranoid:	Individuals who are unable to trust and feels that they are being persecuted by those with whom they come into contact. Their reaction to this believed persecution may be aloofness and expressions of distrust and resentment. They may sometimes show outbursts of anger and bitterness. These outbursts cause people to avoid them thus increasing loneliness and distrust.
Parental Rejection:	Denial of affection and attention by one or both parents.
Passive-Aggressive Personality:	A personality disorder in which the individual shows aggressive feelings in passive ways such as pouting, stubbornness and denial.
Penis Envy:	A Freudian concept which maintains that the female is jealous of the male because of his penis.
Perseveration:	Repeatedly asking the same questions, making the same responses, using the same words or phrases, doing the same action. Constant repetition of the same word or idea in response to different questions.
Personality:	The total configuration of the behavior of an individual. It reflects physical and mental activities, attitudes and interests.

Phallic Phase:	The third stage in psychosexual development occurring when the child is between the ages of 2 and 6. During this period, the child's interest and curiosities are centered around the penis in boys and the clitoris in girls.
Play Therapy:	Type of therapy used primarily with preschoolers. Medium in the form of dolls, clay, water etc., are made available in an effort to help the child reveal problems on a fantasy or role play level. The therapist/teacher provides explanations for the child.
Primary Caretaker:	The adult who assumes the responsibility of taking care of the child.
Projection:	An unconscious defense mechanism by which an individual attributes to another thoughts, ideas and/or feelings that he considers unacceptable.
Psychiatrist:	A medical doctor whose speciality is the study and treatment of mental diseases.
Psychoanalysis:	The Freudian method of treatment of mental illness geared to help a person gain insights into their unconscious motivations and conflicts in an attempt to bring about a change. Psychoanalysis involves delving into the past to seek and identify causes of the problems.
Psychologist:	An individual with an advanced degree, usually a Ph.D., who specializes in the study of the mental process and the treatment of mental disorders.
Psychosexual Development:	Personality development and functioning as they are affected by one's sexuality : not limited to sexual feelings and behavior alone.
Rapport:	A conscious, harmonious accord: that reflects a positive, trusting relationship between two people. With children, a friendly, cheerful, relaxed manner on the part of the teacher/therapist etc. helps to relax the child and develop rapport.
Reality:	Everything that is perceived by a person's special senses and validated by others.
Reality Testing:	An ego function that involves an objective evaluation of the world outside oneself. How a person evaluates reality and attitude toward reality is dependent upon early experiences with significant persons in his /her life.
Regression:	An unconscious defense by which an individual returns to earlier, less mature patterns of behavior.
Repression:	An unconscious defense mechanism by which an individual blocks out or removes from memory those things, feelings, ideas, incidents, that are unpleasant or unacceptable.

Residential Treatment

Facility:	A center, hospital or institution where an individual lives and receives treatment relative to particular need.
Resistance:	A conscious or unconscious opposition to the uncovering of the unconscious.
Retardation:	Slowness of development or progress : terms most frequently used are mental retardation which refers to slowness or arrest of intellectual development, and psychomotor retardation which refers to slowness of psychic and/or motor activity.
Role Play:	Training technique in which a person "acts out" his reality roles so that he can function more effectively in that role, such as teacher, student, parent, etc. In the therapeutic setting the technique is used to help the individual overcome his fears, conflicts and anxieties, by repeatedly acting out the role. The therapist is available to interpret and support.
Schizophrenia:	A mental disorder, considered by many the primary psychotic state. It is a break from reality characterized by disturbances in thinking, mood and behavior. Behavioral symptoms include delusions, hallucinations, incoherent speech, withdrawal and bizarre behavior.
School Phobia:	A child's sudden fear and refusal to attend school.
Self-actualization:	The ability of an individual to make full use of capabilities and potential. This is characterized by high levels of objectivity, creativity, kindness, lack of inner conflict and capacity for joy and happiness. According to Maslow, self-actualization is one of man's basic needs but it is fully realized in only a few people.
Self-awareness:	The ability to know, understand and evaluate what one is experiencing.
Sensitivity Training:	Process with the primary aim of helping the individual develop self-awareness and understanding.
Separation Anxiety:	An infant or child's fear of being removed from his mother or primary caretaker.
Sibling Rivalry:	Competition among children for affection, esteem, and attention from their parents. This is a normal part of the development. It is usually facilitated if the parent shows favoritism or if the child is unprepared for the birth of a new baby.
Socialization:	Process of learning and using inter-personal and interactional skills according to and in conformity with one's own society.
Superego:	The third component of the mental processes that deals with moral attitudes, conscience and a sense of guilt. It results from internalization of societal standards and parental attitudes and influences.

Supportive Techniques:	A method interaction used primarily in the treatment of children with emotional problems, by which the individual is encouraged to verbalize his feelings as opposed to displaying negative behavior as a means of dealing with feelings. The therapist interprets the child's actions and feelings for him/her and gives the child positive outlets for behavior.
Surrogate Parent:	An authority figure who functions as parent.
Therapeutic Milieu	See milieu therapy.
Therapeutic Nursery School:	A method of group treatment for children with emotional handicaps. This method was originally introduced by Anna Freud. It involves lay therapists working with 5 - 7 children for three hours per day. The parents are closely involved in the therapeutic treatment process.
Tic:	Involuntary, repetitive motor movement of a small part of the body.
Toilet Training:	The process of teaching a child to control bladder and bowel movements. The average child is usually ready to be toilet trained at the age of two. The method by which toilet training is handled, and the parents attitude toward toilet training have important psychological implications for the child's later development.
Trauma:	An upsetting event or experience.
Traumatic Experience:	Occurrence that precipitates or aggravates an emotional problem.
Withdrawal:	Retreating from interpersonal contact and social-involvement.

B. METHOD OF INSTRUCTION:

1. Group workshop sessions in which the various terms are thoroughly discussed. The student is introduced to mental health terminology prior to the time that he/she is given the opportunity for practical application. However, the trainer should remember that an individual learns best through experience. As a result, the students should not be expected to completely understand and internalize the terminology until they are in a situation where these terms are practically applicable.
2. The student is provided with ample opportunity to observe children who are being treated for emotional problems. Such opportunities are available through group therapy situations such as therapeutic nursery schools run by state agencies, local Head Start and/or Day Care programs, local universities and hospitals.
3. If possible, arrangements should be made for the student to gain direct practical experience. Most therapeutic treatment programs hold the philosophy that consistency is an important part of the treatment process. Changes cause the emotionally disturbed child to regress and to act out. This hampers the treatment process. If the practical involvement of the student is to be helpful to both child and student, arrangements that would allow the student to participate on a daily basis for a pre-determined time period should be made.
4. Time is set aside at the end of each day for follow-up discussion, interpretation and evaluation. If these sessions are to be productive ones, the person leading the discussions should observe the student during the practicum experiences.

C. RESOURCES

1. Practicum sites: Hospitals, day care programs, Head Start programs, local universities and other related community agencies.
2. Books:

Freedman, A., Kaplan, H and Saddock, B. Comprehensive textbook of psychiatry. Baltimore, Md.: Williams and Wilkins Co., 1972.

Freud, Anna, Introduction to the technique of child analysis.

Mussen, P. The psychological development of the child. New Jersey: Prentice-Hall Inc., 1963.

3. Audio-Visual Aids:

Audio-visual tapes of children in treatment. A limited number of such tapes are available through the National Child Day Care Association.

Parent's Magazine Educational Enterprises, Audio Cassette Package.
Set One: Defining Children's Needs.
Published by Parents Magazine Films Inc., 1977.

OBJECTIVE FOUR

Understand the theory underlying the supportive framework as well as the practical application of the techniques used in the supportive framework.

A. CONTENT

The term "supportive framework" has its origin in the German word for which the English translation is "swaddling." While the word swaddling is, in itself, restrictive, the term supportive framework is an all encompassing one. If it can be defined in a few words, the supportive framework is a positive method of human interaction. Too often, however, the supportive framework is limited to use with children who are experiencing emotional difficulties. This limited usage probably stems from the fact that the supportive framework is, in itself, therapeutic. It involves helping children cope with every day life experiences; encouraging children to verbalize their feelings and/or verbalizing children's feelings for them; helping children understand their feelings and experiences; giving children positive ways of coping with feelings and experiences; helping children channel negative behavior into more positive behaviors; giving children reasons for their behaviors; using positive supportive words with children rather than degrading, belittling or threatening children; being honest with children; treating children with respect.

An example of the supportive framework in action is: "J" deliberately knocked over the tray with the hypodermic needles when he came into have his blood drawn. This made the adult angry. However, the adult realized that "J" knocked over the tray because he was scared. The adult said, "J", I know that you are scared because you are going to have your blood drawn. It is okay to be scared, but I cannot let you knock over the needles. That behavior makes me very angry. You need to pick up the needles; I'll help you. You're okay, I

still like you. It is your behavior that I do not like. After we have picked up the needles, I will draw your blood. It will hurt a little, but it will be over soon. I'll show you how I draw the blood..."

In this example, the adult displayed awareness and sensitivity in understanding the reasons for the child's behavior. The adult explained the child's behavior to him, gave the child positive alternatives, reassured the child, and was respectful and honest. How do you think the child reacted? "J" began to cry quietly. He looked at the adult for a while. The adult hugged him, reassured him that he was okay, but he had to help pick up the needles. After about two minutes, "J" began to pick up the needles, still crying. The adult helped him. "J" kept one needle to explore, but was told by the adult that he would have to return it when he was finished. The adult then explained, while drawing the blood, everything that was being done. "J" winced when the needle stuck and began to cry softly. The adult let "J" hold the cotton on the arm while getting the band-aid. When the entire procedure was over "J" took a tissue that was offered him, wiped his eyes, returned the needle that he was exploring and ran into the wait-room smiling and shouting, "Hey, it did not hurt much."

Had this particular adult not been trained in the use of the supportive framework, he/she might have yelled at "J" for knocking over the tray and demanded that he pick it up. The result may have been a test of will power with both adult and child losing. "J" would probably have thrown a tantrum and gotten out of control. The adult would have been unable to draw the blood.

The above example clearly indicates that the supportive framework is not an alien phenomenon to be reserved for use with the emotionally disturbed. Rather, it provides therapeutic support and encouragement for all children. Fritz Redl (1960), in discussing the therapeutic milieu, outlined many of the techniques that are used in the supportive framework. Some of these techniques are:

."Don't put poison in their soup." This means that when dealing with children, the adult should not threaten, punish or belittle the child. The adult's role should be one of protector, helper, and supporter. Protect the child from traumatic experiences, help him/her to grow and mature, be supportive of the child even when disciplining.

."You still have to feed them." All significant adults in a child's life must ensure that the child's "psychological nourishment" contains all the vitamins and nutrients needed for healthy development.

"Development - phase appropriateness and cultural background." Adult-child interactions should be stylistic, depending on the child's age. The very adult behavior that is reassuring to a five year old may produce hostility in an adolescent.

."Elasticity is necessary." The adult must be able to be flexible, to yield to specific demands, to allow leeway for exceptions and regression, to pick up on cues, to deal with situations as they arise.

."Education for life." One of the adults roles is to help children move away from highly supervised dependence and assume the role of an independent functioning human.

The "life-space interview" technique, also described by Fritz Redl (1960), is a technique that is used by those individuals who implement the supportive framework. According to Fritz Redl (1960), life space interviewing plays an important part in the lives of all children because it assumes a mediating role between the child and what life holds for him/her. Life space interviewing is built around the child's direct life experiences in connection with the specific issue that is in focus. For example: The developmental teacher had planned a field trip. The four children were getting their coats on. Everyone was excited. There was a delay because the parking lot entrance was blocked and the driver could not get the car out. The children were anxious and excited. Two children started bickering and Tyrone was hit harder than he could take. He ran back into the room crying and swearing that he hated field trips and he would never go on another one. He hated those "stupid teachers anyway." The teacher's role, in this instance, would be to go to Tyrone and help him sort out his emotions and support him. If the behavior exhibited is a pattern, the teacher should

use this opportunity to give Tyrone some insights into his behavior, and help him see how he may have caused the situation. The life-space interview technique, therefore, has two goals:

- a. Clinical exploration of life events which involves helping children understand the reasons for their actions and affect, helping them cope, providing alternative behaviors, helping children to see the value of other defenses and helping them widen their adaptional skills.
- b. Emotional first aid on the spot which involves showing sympathy and understanding, providing therapeutic support when children express feelings that they do not understand, keeping communication open even if the child cannot deal with the issues at hand, helping children to understand and adhere to rules.

B. METHODS OF INSTRUCTION

1. On The Job Training:

In order to implement the supportive framework an individual must not only know the theory, but also internalize the processes involved and incorporate these processes as part of his/her everyday patterns of interaction. The supportive framework, therefore, cannot be taught in a short time period. Part of the training processes must be on-going, on-the-job training. This on-the-job training should be conducted by an individual who is conversant with the supportive framework and has practical experience with the techniques and strategies. Ideally, the on-the-job training sessions should be held weekly, and the participants in the training should be observed, while working, by the trainer.

2. Workshops:

Training must also involve didactic workshop sessions. Role play experiences should be incorporated as part of these sessions. Role plays aid in the clarification of terminology and application of the techniques. Clarification may be easier if the initial role plays showed two ways of dealing with the situation: the supportive framework approach and a non-supportive approach. The following is a suggested role play activity.

Situation: A group of four children are waiting for physical examinations in the waiting room. Two of the children are playing with a lego game, one child is writing on the chalk board. The fourth child is alone, holding a wooden telephone. One adult is in the room. She starts over to Mary (the child is sitting alone). Before she has a chance to reach Mary, Mary throws the telephone and hits one of the children who is playing lego.

Reaction One: (Using the supportive framework)

Adult takes Mary by the hand, and walks over to Keica (the child who was hit). She hugs Keica and says, "Keica, I know that hurts. You also feel bad that Mary hit you. Mary feels bad too. What Mary wanted was to play with you and she did not know, right then, how to ask you. I think she was probably afraid that you would say no. Mary was not angry with you. She was lonely and hurt. Sit here for a minute, let me talk with Mary and I will be right back." Keica goes back to play. "Mary, I can't let you throw things and hit people. It hurts when you do that. If you want to play with Keica and Tonya, you need to ask them. When you are ready, ask Keica and Tonya if you can play with them. If they say no, it does not mean that they do not like you, it means they are angry because you hit them." Mary pouts for a few minutes, then yells across the room, "Can I play with you all?" Keica and Tonya respond, "Yes, when we are finished this game."

Reaction Two: (Using the non-supportive framework)

Adult goes to Mary and says. "Give me those blocks. Now, sit here until you learn not to throw things at people. You're always doing that..Keica stop crying, she did not hit you that hard."

C. RESOURCES

1. Books:

Freud, A. Normality and pathology in childhood. New York: International Univ. Press, 1964.

Freud, A. Psychoanalysis for teacher and parent. Boston: Beacon Press, 1935. Revised edition, 1960.

Freud, A. The Psycho-analytic treatment of children. London: Persey, Land, Humphries & Co., Ltd., 1954.

Hymes, J. The child under six. New Jersey: Prentice Hall Inc., 1967.

Redl, F. When we deal with children. New York: The Free Press, 1960.

Spivack, G. and Shure, M. Social adjustment of young children. San Francisco: Jossey-Bass Publishers, 1974.

Stein, M., and Ronald, D. Educational psycho-therapy for preschoolers. *Journal of Child Psychiatry*, 1974, 13 (4).

2. Consultant psychiatrist, psychologist or educator trained in the use of the supportive framework.

3. Audio-Visual Aids:

Video tapes produced by the National Child Day Care Assn., Wash., D.C. Rentals available through the National Child Day Care Association, 1501 Benning Rd., N.E. Washington, D. C. 20002

Film Strip Series: Parent Education

Film Strip Set: "Day to Day With Your Child,"

Published by: Parents Magazine Films, Inc., New York.

Film Strip Series: Child Development

Film Strip Set: "Emotional and Social Growth in Children,"

Published by: Parents Magazine Films Inc., New York.

4. Practicum sites, specifically Therapeutic Nursery Schools. In most states Therapeutic Nursery Schools are operated through the Department of Human Resources, local universities and child development programs.

D. METHOD OF EVALUATION

1. Written examinations can be designed to serve at least a threefold purpose: to determine if the student is able to apply the knowledge and to determine if the student is able to interpret what he/she has learned. The following is an example of some of the kinds of questions that can be included in a written examination on the subject of the supportive framework:
 - a. Factual:
 1. Define the term "supportive framework."
 2. List six ways in which one is expected to deal with children when using the "supportive framework."
 3. Fritz Redl discusses several techniques that comprise the supportive framework. List at least five of those techniques.
 - b. Application:
 1. Two children are fighting in the waiting room. Discuss, in detail, how you would handle this situation.
 2. Ceal comes into the nursery school crying. Her mother pushes her into the classroom and says, "Girl, shut up and go in there." Discuss how would handle this situation. In your discussion include what you would say to both mother and child.
 - c. Interpretation:
 1. What does the following sentence mean to you: "Children's psychological nourishment should contain all the vitamins and nutrients they need for healthy development."
 2. "Giving emotional first-aid on the spot" is one of the goals of the life-space interview technique, described by Fritz Redl. Discuss, in detail, your interpretation of that goal. In your discussion cite examples of how emotional first-aid is administered.

2. Continuous observation of the trainees during practical experiences is an important part of this evaluation. The supportive framework has been defined as a positive method of human interaction. To determine whether or not the interaction is occurring the student must be observed. The following is an observation instrument that may be helpful. The instrument covers twenty-five items. You may want to include more. Definitions that are compatible with the supportive framework are included.

NATIONAL CHILD DAY CARE ASSOCIATION
EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROGRAM

OBSERVATION INSTRUMENT
Experimental Form

Trainees Name _____

Date _____

Observation 1 2 3 4 5

Time of Observation _____

Place of Observation _____

Observers Name _____

- | | | |
|---|----------------------|--|
| 1. Able to accept suggestions | <u>7 6 5 4 3 2 1</u> | Defensive about suggestions |
| 2. Recognizes mistakes | <u>7 6 5 4 3 2 1</u> | Does not recognize mistakes |
| 3. Involves self in activities | <u>7 6 5 4 3 2 1</u> | Does not involve self in activities (with-drawn) |
| 4. Accepts self | <u>7 6 5 4 3 2 1</u> | Dissatisfied with self |
| 5. Supportive | <u>7 6 5 4 3 2 1</u> | Nonsupportive |
| 6. Warm and sincere liking for children | <u>7 6 5 4 3 2 1</u> | Lacks warm and sincere feelings for children |
| 7. Good sense of humor | <u>7 6 5 4 3 2 1</u> | Lacks sense of humor |
| 8. Able to observe children's behavior | <u>7 6 5 4 3 2 1</u> | Not able to observe children's behavior |
| 9. Able to communicate own feelings | <u>7 6 5 4 3 2 1</u> | Not able to communicate own feelings |
| 10. Can verbalize feelings of child | <u>7 6 5 4 3 2 1</u> | Cannot verbalize feelings of child |

11. Helps children with impulse control 7 6 5 4 3 2 1

Does not help children with impulse control

12. Can interpret the child's feelings 7 6 5 4 3 2 1

Cannot interpret the child's feelings

13. Able to record children's behavior 7 6 5 4 3 2 1

Not able to record children's behavior

14. Able to establish rapport 7 6 5 4 3 2 1

Unable to establish rapport

15. Praises child 7 6 5 4 3 2 1

Does not praise child

16. Gives child opportunity for success 7 6 5 4 3 2 1

Does not give child opportunity for success

17. Physically supportive 7 6 5 4 3 2 1

Physically distant

18. Sets limits 7 6 5 4 3 2 1

Does not set limits

19. Consistent in behavior 7 6 5 4 3 2 1

Inconsistent in behavior

20. Shows knowledge of appropriate stage concern in interaction with child 7 6 5 4 3 2 1

Does not show knowledge of appropriate stage concern in interaction with child

21. Helps child appropriately test reality 7 6 5 4 3 2 1

Does not help child appropriately test reality

22. Encourages age appropriate behavior 7 6 5 4 3 2 1

Does not encourage appropriate behavior

23. Recognizes age-appropriate emotional concerns 7 6 5 4 3 2 1

Does not recognize age appropriate emotional concern

24. Talk with child 7 6 5 4 3 2 1

Does not talk with child

COMMENTS:

DEFINITIONS FOR ITEMS IN OBSERVATION INSTRUMENT

1. Listens to what is being said by the teacher (or other person in charge) and acts upon it. Does not offer rationalizations for his/her behavior.
2. Is able to, either when told by the teacher or through his own awareness, realize that he has made a mistake. It is also necessary to show that he accepts the fact that a mistake was made, and is able to change the behavior freely.
3. The trainee takes an active part in initiating and carrying out activities with the children and/or in following through with activities as directed by the teacher.
4. Appears calm and in control of self and situation. Appears to be at ease with the child and with the situation. Is able to shrug off accidents - does not take things personally.
5. Supports child in the way he/she needs to be supported at any specific point in time. This may mean a hug or a positive word, but it may also mean being firm, restricting the child, etc.
6. Appears to genuinely like all children. Does not show favoritism or have special teachers pets. Is able to admit when she/he cannot deal with a child at any specific point and is able to ask the teacher to take over.
7. Shows humor (in keeping with the child's level). Can tell jokes, make the children laugh, relax and feel comfortable. Can accept being the object of a joke.
8. Is able to pick up on cues from children and follow through on them. Observer should note the time interval between a child's behavior and the trainees reaction to the children. e.g. Does the child get into a potentially mischievous situation that the trainee does or does not observe.
9. Is the trainee able to verbally express how he/she feels about a particular event or situation. e.g. Does he/she use sentences that begin with "I feel, "Johnny, that makes me angry," "I am happy that etc..."
10. Is the trainee able to verbalize for the child how he/she is feeling. e.g. "It's okay to be afraid" or "I know it's hard to share the toy."
11. Helping the child with impulse control may range from a word or touch to helping the child "use his/her brakes." Examples of this might range from telling the child to stop engaging in an undesirable behavior to literally physically holding the child to restrain him.

12. Interpreting child's feelings include verbalizing the child's feelings, as well as the reason for the feeling (the because) e.g. "You're afraid because you have never been to the dentist and you are not sure what he/she will do."
13. The trainee accurately completes the adjective check list. (This may often not be observed by the observer).
14. Appears to be relaxed with child, and is able to help the child relax. Is able to be conversant and/or communicative with child. Takes the time to get to know the child before making demands.
15. Praises child verbally by using words such as "good, "you really did well Johnnie, etc." or praise non-verbally by facial or body gestures e.g. a smile, hug, etc.
16. Does the trainee involve the child in tasks where the child might succeed. Does the trainee select tasks according to what she/he knows to be appropriate for the child. Is the trainee able to cue in to the individual child's ability or special talent and select tasks accordingly.
17. Is the trainee able to give a positive hug or touch when the child needs it. On the other hand, can the trainee physically restrain (hold the child's brakes when necessary).
18. Does the trainee give the child a clear indication of what the limits are? Is he/she consistent in enforcing the limits. e.g. "You cannot hit Johnny, even though you are angry." "We play with the blocks in the block area, please take them back."
19. Is the trainee applying the same rules, limits etc. to each child in every situation that arises.
20. Does the trainee seem to know what tasks, behaviors etc. are appropriate for children at specific ages. Does he/she seem to know what behaviors can be expected of children, even if he/she is not familiar with the particular child in question.
21. Take the situation where Johnny (child) sees Alice reprimanded for spitting; Johnny then elects to throw one to see what the trainee will do. In such case the trainee should show consistency and restate the rules, giving the child clear evidence of the reality limits.
22. Here the trainee should evidence that he/she can implement No. 20. Knows age appropriate behavior and can help child choose tasks that are appropriate to his age and level of development.
23. The trainee should show by acceptance of the child's behavior that he/she has the skill for e.g. if a three year old is showing signs of "separation anxiety" that's okay. However, if a ten year old is showing signs of "separation anxiety"--the trainee should be supportive of the child, but should speak to the appropriate person about referral etc.

3. Self-Evaluation:

The student should be given the opportunity to daily review and discuss the days activities. The trainer should be present during these discussions. His/her role would be to give insight into issues raised and provide support.

OBJECTIVE FIVE

Understand the ego functions and how they relate to healthy emotional growth.

A. CONTENT

Definition:

The ego is that part of the mental processes that enables a person to decide how to regulate their behavior.

The ego functions are the twelve basic processes than an individual acquires as part of the development of the ego.

The following is a list, with definitions, of the twelve ego functions. This list was developed by Alberta Vallis, M. D.

1. Relatability: How does he respond to people? his mother? his father? his siblings? his peers? his teachers? non-human objects?
2. Self-Esteem: How does the child feel about himself? He only feels good if he thinks you like him.
3. Identification: Does he see himself as a happy, loved, boy or girl? How does the child interact with peers of the same sex?
4. Motility: Is he hyperactive and overly involved with things or is he withdrawn, slow and passive?
5. Judgment: Can the child accurately interpret the actions?
6. Perception: How does the child see the world? Is he out of step or does he see and hear ideas like others?
7. Defenses: How does the child cope with situations? Does he cry to avoid, scream to make distance, act like a baby or use age appropriate ways of feeling comfortable and getting through little situations?
8. Reality Testing: Can he distinguish between the ways things are and the way he could like them to be? Is he able to make the transition to reality from the play world? Can he stop pretending?
9. Memory: Can the child concentrate long enough to invest in keeping facts? Can the child follow age appropriate commands? Can he repeat simple word patterns? Can the child relate his/her present activity with a past experience?

10. Anticipation: Has sameness been consistent enough for him to trust that his wishes will be granted and that his mother will return? Does he anticipate at all?
11. Delays Gratification: Does he need it now-or can he wait, knowing and trusting?
12. Availability to Learn: How much do the child's emotional problems inhibit his availability to succeed in a normal classroom? Can he hear, discriminate, organize, and learn?

The acquisition of the ego functions are developmental in nature. Children begin to acquire various ego functions at certain ages as part of emotional development. For example, the infant begins to show signs of relating to people, especially his mother, at approximately six weeks to two months of age. If the child is to become a happy healthy individual-if he is to develop a healthy ego - he must be loved, supported, cared for, protected, encouraged, and physically and psychologically nourished. Use of the techniques that are incorporated in the supportive framework is one way of attempting to ensure healthy emotional development.

B. METHODS OF INSTRUCTION

1. Prior to teaching the ego functions a review is necessary. There are several pre-requisites to understanding the ego functions.
 - a. Knowledge of the stages of emotional development: behaviors that one can expect of children at various ages.
 - b. Knowledge of the supportive framework. Knowledge here includes factual understanding as well as the ability to apply the strategies and techniques.
2. Didactic workshop sessions that would include:
 - a. The Freudian theory of the various mental processes: id, ego and super ego. A brief outline of these three processes would suffice. The student would need to know these three mental processes and how they are inter-related.
 - b. Didactic workshops that emphasize the ego and its development. Each ego function should be dealt with separately and attempts should be made to show how these functions are applicable to various stages of development.

3. The student should be given the opportunity to observe children. The following is a limited list of behaviors, with explanations, that can be used as guidelines for observations. Note that the explanations provided are specifically geared to the pre-school child. They could, however, be adapted for children at various ages.

A GUIDE FOR OBSERVATION OF BEHAVIORS

1. **SHARES WITH OTHERS:** Does child share voluntarily? Does he share when asked? Crying,bitting, throwing tantrums or showing other signs of unacceptable behavior, when asked to share are not positive signs that the child can share.
2. **THUMBSUCKING:** First be aware of child's age - thumbsucking in times of stress or at naptime is not uncommon at age 2 or 3 years. Constant thumbsucking at any age is a concern. This category also includes tongue sucking, finger sucking, sucking clothing, etc.
3. **NEAT:** Is child himself concerned with his personal appearance and the appearance of the classroom? Over concern should be noted. Over concern includes inability to participate in so called messy activities such as finger painting, due to fear of getting dirty, etc.
4. **ORDERLINESS:** Does the child go about tasks in a logical, efficient manner, e.g., placing toys in proper places, following schedule of the class, or does the child function randomly.
5. **SENSE OF TIME:** Is the child aware of where he's supposed to be at a given time during the day. Does he understand the sequence of the activities presented. What comes next, e.g. after lunch, wash up, brush your teeth and take a nap.
6. **NEED TO SEPARATE FROM GROUP:** Does child have to be sent away from group because of disruptive behaviors, or the inability to settle down and focus in on activities? How frequently does this separation occur?
7. **SHYNESS:** Does child seem uncomfortable in the presence of others? This may be exhibited by moving away from others, lack of eye to eye contact, hiding face, very little verbalization with others.
8. **ACCEPT PRAISE:** Is the child confident enough to accept praise without the need to act out or pretend he/she hasn't been complimented? Does praise seem to make him over confident and arrogant?
9. **RELATES TO PEERS OF THE SAME AND OPPOSITE -SEX:** Does child play well with peers of the same sex? Does child play well with peers of opposit sex? Does child see himself as a girl/a boy?
10. **EXTERNAL CONTROL NEEDED:** Does child only keep himself together in the presence of adults? Does teacher have to direct him often? Does the child need to be restrained by an adult?

11. **ENJOYS PLAYING ALONE AT TIMES:** Does child enjoy playing alone at times without peer or adult assistance? How frequently does this activity occur?
12. **ENJOYS PLAYING WITH OTHERS:** Does child play with others? Does child seem to enjoy being a part of the group? Does the child appear happier in group than individual play?
13. **RESPECTS THE RIGHTS OF OTHERS:** Does child understand that others have rights too? Example - the teacher is there for everybody, or he (child) cannot take toys from other children at will.
14. **CLINGS EXCESSIVELY TO ADULTS:** Does child want constant attention from adults - (familiar adults or strangers)? Does he constantly hold arms or legs of adults, touch or rub constantly.
15. **UNDULY SLEEPY:** Does the child appear drowsy, listless and tired in the morning or after nap? Does the child fall asleep in the classroom or act sleepy when it's not naptime?
16. **FEARS LOSS OF CONTACT WITH ADULTS:** Does child seem afraid when adults leave? Does child need excessive tactile or verbal stimulation from adults? Does child keep close to teacher, parents or any adult who happens to be present? Does child appear afraid of being left alone?
17. **OVER RELATES TO INANIMATE OBJECTS:** Does child over invest in fantasy? Does child pretend to be an inanimate object such as cartoon characters, super heroes, and monsters? How old is the child? How often does this behavior occur?
18. **SENSE OF SELF WORTH:** Does child like himself? Does he show pride in his work? Does child defend self appropriately? Is he easily intimidated by others?
19. **HIGH DEGREE OF DEPENDENCY:** Is child dependent on adults even for small or simple tasks? Is child overly dependent on peers, teachers and siblings?
20. **PASSIVE BEHAVIOR WITH OTHER CHILDREN:** Does child accept roles assigned to him by other children? Is he/she always a follower. Does he lack aggression as far as defending self, verbalizing needs and wants with other children? Can child get involved with other children and activities on his own or does the teacher have to involve him?
21. **APPROPRIATELY AGGRESSIVE:** Can the child take roles as leader and follower? Does child defend self appropriately? Does he assert himself? Does child establish peer relations, initiate activities during free play with minimal confusion with peers?
22. **COMMITTS SELF DESTRUCTIVE ACTS:** Does child deliberately hurt himself? Does child take pride in showing scars and scratches?
23. **ABUSE:** Hitting, biting, pulling, spitting, pinching and verbal insults are all types of abuses. Does child use abuse as a means of attempting to make friends or to communicate the desire for attention? Does child use abuse as a means of displaying anger?

24. **CHILD TEST LIMITS:** Does child constantly ask questions concerning the classroom rules? Does child knowingly disobey the rules? Does child tease to see end results?
25. **CAN DELAY GRATIFICATION:** Can child wait his turn? Does child become angered or fidgety when he has to wait his turn? Does child need to hear his work is pretty to avoid destruction of work? Does child need praise immediately after tasks?
26. **DAY DREAM:** Child appears not to listen, child's eyes are focused in one direction, child's face is usually blank. Child appears completely unaware of his surroundings.
27. **OFTEN BLAME OTHERS:** Child places blame on others regardless of who's responsible for act. Unable or unwilling to take responsibility for his own actions?
28. **INABILITY TO CONCENTRATE:** Attention span for age is inappropriate. Is child easily distracted? Does child have trouble attending to activities designed for his age? Does child move from one activity to another in short spans of time without completing any activity? Be certain of child's age.
29. **CURIOSITY:** Does the child ask questions about his environment? Does he question frequently with a true desire for an answer? Does the child explore on his own?
30. **TROUBLE ACCEPTING ROLE:** Does the child see self as girl or boy? Does the child confuse his role, e.g. girl insist upon being a boy or man or vice versa? Does child see self as an adult? Does he constantly assume an adult role?
31. **CREATIVITY:** Does the child draw pictures on his own, design buildings from blocks, make designs with play dough? Does child make up and tell stories? Can child follow through with own ideas as
32. **EXPLORATIVE:** Does the child explore or investigate his surrounding trying to find information to answer his own questions? Example, Does he bring insects to school to find out more about them? Does child ask who, what, where, when, and how?
33. **MANUAL DEXTERITY:** Has the child established handedness: predominant use of left or right hand? Does the child use both hands without showing a preference for one or the other?
34. **JUDGEMENT OF ACTS:** Until a child is six years old he will usually deny acts that he has done. After talking with a child about a specific act, is he able to make a judgement concerning the act?
35. **COORDINATED IN MOTOR AREAS:** Can child walk, run, jump, cut, draw, etc. at an appropriate level for his age?

4. Allow time for detailed analytic discussions after student has been introduced to each observation. The procedures involved in an analytic discussion are detailed under Emotional Objective No. one page 135. Discussion should be an integral part of every didactic workshop session.

C. RESOURCES

1. Books:

Bowdoin, R. The Bowdoin method. Book 4: "Words that win children" Book 6: "The importance of good feelings." Book 10: "My mommy likes me." Tennessee Webster's International Tutoring Systems, Inc., 1976.

Erickson, E. Childhood and society. New York: The Norton Press, 1963.

Freud, A. The psycho-analytic treatment of children. London: Percy, Land, Humphries and Co., Ltd. 1954.

Jenkins, G and Shacter, H. These are your children. Illinois: Scott, Foresman and Co., 1975.

Long, N. Morse, W. and Newman, R. Conflict in the classroom. California: Wadsworth Publishing Co., Inc., 1971.

2. Flyer and Pamphlets:

Vallis, A. "Emotional Development - Birth to Six Years of Age."
Vallis, A. "Ego Functions."

Both available through the National Child Day Care Association, Washington, D.C.

3. Publications by U.S. Department of Health, Education and Welfare, Office of Child Development, Washington, D.C., 1974.
Responding to individual needs in head start. Part 1: "Working with the individual child."

Available from the Government Printing Office, Washington, D.C. DHEW Publication No: (OHD) 76-31075.

4. Audio-Visual Aids:

"The Aggressive Child." McGraw Hill Films, 1221 Avenue of the Americas, New York, N.Y. 10020

"Film Strip Series: The Child's Relationship With the Family. Produced by Parents Magazine Films, Inc., 52 Vanderbilt Avenue, New York, N.Y. 10017.

D. METHOD OF EVALUATION

1. Written examinations that are designed to determine the acquisition of the information taught as well as the individuals ability to apply and interpret the information. Some questions that may be included on a written examination that is designed to evaluate this objective are as follows:

Factual:

- a. Define the id, the ego and the super-ego.
- b. List the twelve ego functions that were discussed.

Application:

You are working with a four year old who constantly picks on other children and disrupts their games. He knocks over materials with which children are playing, he hides toys from the other children, and he is physically abusive. Think about the ego functions. Does the child's behavior indicate possible abnormal development in any of the ego functions? If your answer is yes, say which of the ego functions are affected. Give detailed reasons for your answer.

2. Interpretation:

Explain, in detail, how the ego functions relate to healthy emotional development.

2. Observations by the trainer and self-evaluations should be an on-going part of the evaluation process.
3. Self-evaluations are important.

OBJECTIVE SIX

Apply the knowledge gained, as part of objectives one through five, in everyday interactions with children.

DISCUSSION

This objective requires application of objectives one through five and does not refer to any new or additional content. A thorough content review should be done, as well as an overall post -test to determine if students have, in fact, acquired the knowledge. In addition, on-going on-the-job observation and frequent supportive evaluation is a necessity.

The following information entitled, "Meeting Common Problems of Children" and "Therapeutic sentencing," is being included here as a guide. Once the student becomes familiar with the use of supportive words and actions when dealing with children, it will become a natural part of their day to day interactions. The trainer can also use this information as a guide to observing the student.

MEETING COMMON PROBLEMS OF CHILDREN

CHILD'S PROBLEM	IT MAY MEAN	SO DO NOT	DO TRY
Physically hurts other children.	Troubled feelings; Anger	Punish him harshly. Act angry yourself. Undermine his confidence in your love. Make him feel his bad behavior means he himself is bad.	Quietly separate the children. Take away the hurting object calmly and firmly, saying "I cannot let you hurt.." Divert his attention. Help the children play happily together again. Prevent his hurting others by helping him feel loved and by giving him other outlets for his feelings.
Destroys things	An accident. Feelings of helplessness, jealousy, boredom. Wants attention. Excitement, exuberance, curiosity.	Scold; yell or shout. Punish him harshly by spanking or hitting him. Tell him he is bad.	Remove the destructible thing from the child's reach. Substitute something else for what is being destroyed. Provide good place for play. Expect some wear and tear. Provide things to pound and mess and cut and tear. Expand his world by taking him places, letting him see and explore new areas Teach him what he may and may not do.

MEETING COMMON PROBLEMS OF CHILDREN: CONTD.

CHILD'S PROBLEM

Uses "bad" language.

IT MAY MEAN

Trying something new.
A joke, imitation, getting
attention, letting off
steam.

SO DO NOT

Get excited, act embar-
rased or shocked. Scold
or punish him. Over-
emphasize the words.

DO TRY

Relax - remember what
it means. Calmly tell him
to stop. Trying rhyming
words or offer other
simple words as a sub-
stitute. Give him healthy
outlets for his feelings.

Won't share.

Too young. Need for
experience in owning and
sharing.

Snatch from him. Scold
or hurt him. Tell him
you do not like him.
Play favorites in settling
disputes.

Help him enjoy sharing.
Be sure he has things
that are his. Let him
know what it means to
own things. Be fair in
children's squabbles over
things. Love him so he
feels secure. Provide ex-
periences as he is ready
for them. Provide dupli-
cate equipment for
young children.

Sucks thumb (or fin-
gers).

Needs more sucking.
Needs loving, cuddling,
assurance, comforting.
Fatigue.

Force or restrain (No
mitts or guards or tips
or such). Punish, scold,
coax, threaten, bribe.

Provide sucking satisfac-
tion. Give more satisfac-
tions, love, attention,
pleasure. Find out what
his wants and needs are
and provide as best you
can. Relax and realize
that it rarely lasts.

Nail chewer, hair or
clothes twister.

Needs comfort and se-
curity. Life is too hard.
Too many pressures.

Call him nervous. Force
him to stop. Tie or
restrain his hands. Scold
or punish him.

Reassure him that you
like him. Love him, give
him security. Remove
unnecessary pressure.

MEETING COMMON PROBLEMS OF CHILDREN: CONTD.

CHILD'S PROBLEM

Still wets.

IT MAY MEAN

Not ready for training. Too much pressure on early training. Resistance or rebellion. Insecurity, fear.

SO DO NOT

Make an issue of wetting. Threaten, shame or punish. Bribe or reward. Insist that he tell you when he should get to the toilet. Tell him that you do not love him.

DO TRY

Accept it and him as gracefully as you can. Expect some accidents. Give him your affection freely. Let him know that you have confidence that he will do better some day. Help become independent in other ways and encourage him to grow up. Have extra clothes.

Runs away.

Boredom, exploration, independence, rebellion. Anger.

Make a scene. Cry or make over him. Punish or tie him up. Remove privileges. Unduly restrict.

Find him! Find out why he ran away. Provide alternatives in the play yard. Let him know that you like him. Let him take real responsibilities around the center. Take him on trips with you. Gradually remove restrictions as he is able to take care of himself.

Watches.

Afraid or insecure in group. Insufficient experience with other children.

Make him participate in the group activities. Force him to react. Draw attention to him unduly.

Give him time in the group. Have mother come and stay for awhile...if he is new. Respect him, give him time. Smile at him. Let him know that you are aware of him.

THERAPEUTIC SENTENCING

1. When the child acts silly or clownish:
You can tell mommy how you feel. Say, "Look at me, mommy. Talk to me mommy. Give me a kiss, mommy, etc."
2. When child tries to be boss:
"Mommy, Daddy, etc. are the bosses at home. Teachers are the bosses at school. It is way too scary for little people to try to be the bosses."
3. Monsters, etc.:
"Monsters are only in your mind, in books, or on T.V. They are not for real, so they can't come out and they can't hurt you. And mommy, daddy, teachers, etc. will protect you—we are not going to let anything bad happen to you."
4. When Father is not in the home:
"Daddy did not leave because of anything you did bad—or because of anything you thought. Sometimes big people have problems too, and decide they cannot stay together. But you did not make it happen. And Mommy loves you, and Daddy loves you too (in his own way)."
5. Thumbsucking:
"What it really means is that you want your mommy. But you can tell mommy how you feel, and say, "Give me a hug, mommy (kiss, talk to me, look at me, etc.)"
6. Child who always copies other child:
"You don't have to be like Peter for us to like you. "We like you as William (Mommy loves you as William).
7. New baby in the household:
"I bet part of you feels kind of bad having to share mommy with that new baby. And that is hard, too. And maybe you think mommy loves the baby more, because mommy has to do all those things for the baby—change diapers, hold it, feed it, etc. But when you were a baby—mommy did all those things for you. And mommy still loves you too—as four year old Timothy. You don't even have to be like a baby for mommy to love you. And I bet part of you feels kind of good about being four year old Timothy too." Reinforce all the things 4 year old Timothy can do.
8. Brakes:
When the child's "brakes" are not working—help him, and tell him that when his brakes are not working then you will let him use your brakes.
9. Verbalize anger:
"It's okay to be angry with people. But you can't hit him, etc. and I'm not going to let him hit you either. You can tell him how you feel, say "I am angry with you!"

To the other child, then explain:
"He doesn't mean he doesn't like you, what he really means is that he is angry with you because you took the car away from him".

10. Child who all the time talks about how mommy buys him candy and clothes, etc.:
"Yes. But, what you really want is your mommy! And you can tell mommy how you feel...saying, "Look at me, mommy. Talk to me, mommy. Kiss me, mommy, etc."
 11. Someone close to the child gets sick:
"Grandmother did not get sick because of anything you did bad, or thought. You are not that powerful! Sometimes, people just get sick, but you did not make it happen--and you are okay."
 12. Someone close to the child dies:
"Daddy did not die because of anything you did bad, or thought. You did not make it happen. And mommy is not going to die now, and you are not going to die now either!"
 13. Child withdraws into himself:
"You can't go away from us like that. You have to stay with us!" Hold child. Don't let him "go away."
 14. Someone close in jail:
"Daddy did not go to jail because of anything you did bad, or thought. You did not make it happen. Daddy broke some rules. When daddy was a little boy like you--he did not have a school like this where he could get help with his brakes, and help to tell people how he feels. And that is why he has some problems now. But you are not going to jail when you grow up! No - you sure aren't! And you are okay!" Also, let child know that "little people" can never go to jail.
 15. Name calling:
"We don't call people names here!"
- To child who's been called "bald-headed":
"What he really means is that he doesn't like himself right now. But you are not bald-headed, and Tim is not either!"
- To child who did the name calling:
"Did anybody call you bald-headed? Then deal with that problem...if he says his sister does for instance, let him know that what that means is that she does not feel too good about herself when she says this. Tell the child to let her know that he is not bald-headed...and his name is (fill in child's name)."- 16. Let child know that mommy, daddy, etc. love him--and we sure like him!
- 17. Reassure child that no part of his body can come off. He is all one piece:
"Girls have a vagina--and boys have a penis. Girls are made that way so they can grow up to be mommies, boys are made that way so they can grow up to be daddies. And your penis can never come off. You're okay!"

18. Mommy going to work:

"Mommy has to go to work to earn money so she can buy food and clothes for you—because she loves you. And she lets you stay with us, because she loves you, and she knows that we are going to take good care of you. We're not going to let anything bad happen to you. And Mommy will be back to pick you up." Let him know you understand it's hard when mommy leaves.

OBJECTIVE SEVEN

Know of a variety of referral sources.

DISCUSSION

A list of referral sources in the Washington, D.C. area was developed by the NCDCA-EPSDT project staff. This booklet will not be included here because it applies only to the D.C. area. Referral agencies are unique to a particular community. A booklet containing referral sources should be developed by each program and/or agency.

When developing a referral source be sure to include the following information:

- Name of agency
- Address
- Phone Number
- Contact Person or Persons
- Function of the agency
- Type of service provided/with brief description
- Availability of the service:
 - to whom, for whom.
- Times and days that agency is open
- Requirements of the agency:
 - income, etc.
- Limitations of the agency

CHAPTER FIVE

CHILD DEVELOPMENT

PRIMARY SOURCES:

Erik Erikson. Childhood and society (2nd Ed.). New York: The Norton Press, 1963

Caplan, F. The first twelve months of life. New York: Gosset and Dunlap, 1973.

Jenkins, G. and Schacter, H. These are your children. (4th ed). Illinois: Scott, Foresman and Company, 1975.

Piaget J. Science of education and psychology of the child. New York: Orion Press, 1970.

CHILD DEVELOPMENT

INTRODUCTION

It is essential that we be aware of the differences among children that are due to their endowment, for these innate differences are the keystones on which a child's development will be built (Jenkins and Shacter, 1975). The differences are apparant at birth and continue throughout life. Some children walk at ten months others not until they are eighteen months; some children are ready to read at six, others not until they are eight years old; some children are shy and passive others are outgoing and aggressive. These differences and countless numbers of others are normal. The child who walks at eighteen months walks as normally and competently as the child who walks at ten months. It is with these differences in mind that we enter into the field of child development.

When we say the words "child development" we are talking about the process of interrelated, synonymous growth in several areas: Cognition (intellectual, mental) language, motoric (small and large muscle development), and interpersonal (social).

In representing the various stages of growth in all of these areas - the behaviors and tasks that children are expected to perform - we usually refer to the norm. This essentially means that most children are able to perform certain tasks, and exhibit certain behaviors within various age categories. When looking at these expected behaviors and tasks we must always keep in mind the normal individual differences between children.

OBJECTIVES

The major objectives for the developmental section are as follows:

1. Become familiar with the behaviors and tasks that are expected of children from birth through adolescence, and demonstrate that he/she can apply this knowledge when working with children.
2. Demonstrate the acquisition of a basic understanding of Jean Piaget's theory of cognitive development.

3. Acquire knowledge of the stages in the life cycles as outlined by Erik Erikson.
4. Acquire knowledge of testing strategies, a classification of tests, testing techniques and some of the problems involved in testing.
5. Learn to administer specific assessment instruments.
6. Become familiar with some of the terms commonly used in the field of child development.

OBJECTIVE ONE

Become familiar with the behaviors and tasks that are expected of children from birth through adolescence, and demonstrate that he/she can apply this knowledge when working with children.

DISCUSSION

The following is a gross listing of some of the tasks and behaviors that children are expected to perform at certain ages. Growth takes place simultaneously in several inter-related areas. The following areas are included here - motor, language, cognitive, social. Remember **INDIVIDUAL DIFFERENCES**.

MOTOR

BIRTH TO THREE MONTHS.

Initially all arm, leg and hand movements are reflexive. By the third month he switches from reflex to voluntary muscle control. In the first month, his head flops when unsupported, by the third month he lifts his head, and when put on his stomach he holds his chest and head erect for a few seconds. By three months he can sit supported. At one month he keeps hands fisted. When fingers are pried open he grasps, but quickly releases object. By three months the grasping reflex is fading - he may be unable to grasp an object. At one month the infant stares at objects but does not reach for them. By three months he reaches for objects with both hands.

LANGUAGE

Active: At birth the infant's language is manifested in the form of crying. By the time he is one month old, besides crying he begins to make small throaty sounds, by two months the throaty sounds become cooing. At three months, besides cooing, the infant whimpers, gurgles, squeals and chuckles. By three months he responds, via his language, to mother's smile and talk.

Passive: At one month the infant responds to a voice. This is usually evidenced by the child looking in the direction of the voice. By two months he shows interest in sounds, by three months he is able to distinguish speech sounds.

COGNITION

At one month the infant prefers patterns to color, brightness or size. By two months he startles at or shows facial response to sounds.

During the first month of life the infant is alert one out of every ten hours. By three months the baby stays awake about two hours at a time and is alert for about three quarters of an hour at a time. At one month the infant coordinates his eyes sideways and up and down. By two months he coordinates his eyes in a circle. At one month he follows a toy from the side to center of his body, by three months he follows an object from side to side of body as it is moved slowly in front of him. By two months he focuses on an object a few inches away, becomes very excited when he sees a toy or familiar person, but regards them only if they are in his line of vision. They cease to exist if the child does not see them. By three months the infant begins to show memory. He anticipates feedings and waits for them. During the second month of life the infant begins to show preference for people over objects. He stares at faces, and quiets at the sound of a voice. At this point he also associates behaviors and faces.

SOCIAL

Personal: The infant responds positively to comfort and satisfaction, negatively to pain. At two months he shows distress, excitement and delight. At three months the infant begins to realize that his hands and feet are extensions of himself.

Interaction: At one month the child may smile back to face or voice. At two months he smiles at family members, by the time he is three months smiling is immediate and spontaneous. At one month the baby fixes gaze on mother's face and he may recognize her voice by three months. He totally recognizes mother and responds, differently to her. At one month his expression is generally vague, by three months his expressions are overt: he smiles, vocalizes, turns head in the direction of voices or sounds. At two months the most significant stimulation is touch and oral. At three months social stimulation is important.

Cultural: Daily eating, sleeping and crying patterns are disorganized at one month. By the third month patterns are clearly regulated: needs only one night feeding, and is ready for solids. By three months he sleeps as long as ten hours a night and naps

MOTOR

LANGUAGE

COGNITION

SOCIAL

BIRTH TO THREE MONTHS (continued).

morning and afternoon. At one month bowel movements are as frequent as four daily, by two months he has two bowel movements daily.

THE FOURTH THROUGH THE SIXTH MONTH

By the time the infant is four months he can turn his head in all directions, and can hold head erect for a short time. When on his back he cranes neck forward to try to see his hands catch his feet. By the time he is five months he brings his feet to his mouth and sucks his toes. By five months he begins to roll from stomach to back. By six months he rolls freely from back to stomach and twists and turns in all directions. At five months he may move by rocking, rolling, twisting or by kicking against a flat surface - by six months he can crawl. At four months, when pulled to stand he extends legs, by five months he moves body up and down and stamps one foot then the other by six months he stands with support. At four months he sits supported for about fifteen minutes, by six months he sits with slight support. Balances well. At four months the child will grasp objects

Active: At four months the baby begins babbling, by five months he utters vowel sounds - ah, ooh, etc., and a few consonant like sounds - b, l, d, m. By six months consonant sounds increase. At four mths the baby vocalizes moods of pleasure, by five months he vocalizes pleasure and displeasure. Imitates several tones, varies volume, pitch and rate of utterance.

Passive: At five months the infant responds to human sounds more overtly - he turns heads in the direction of the speaker. By six months he reacts to intonation and reflection differences. Understands and responds to his name.

By four months his vision approximates that of an adult. He sees in color and the eye adjusts to varying distances. At five months eye hand coordination begins to develop. By four months the infant could respond for an hour or more at a time, at five months he is alert for up to two hours, by six months he is alert for more than two hours at a time. At four months he reaches for and grabs object with either hand, using one hand at a time. At five months he grabs and holds with both hands. By six months he persistently reaches for everything he sees without jerky movements. He likes to explore and manipulate objects - he turns around, upside down. Tries to pull paper away and take lids off. During this period he begins to resent strangers, especially women. Memory span increases - remembers his own actions in immediate past. Becoming aware

Personal: Vocalizes moods, enjoyment, indecision and protest. Laughs while socializing and cries if play is disrupted. By five months he shows fear, disgust and anger. He shows anticipation and excitement - breathes heavily. At four months he shows interest in his own mirror image. By six months he differentiates self from mirror image. At six months the infant is aware of the various parts of his body and differentiates self from the world.

Interaction: Vocalizes to initiate socializing. Responds favorably to being held, cuddled, played with. Smiles at human faces and voices. By six months he distinguishes children from adults. He is disturbed by adult strangers, and reaches out to pat strange children. At four months he begins to show interest in playthings, shows preference for one toy over another. He protests if

MOTOR

between index and second fingers, at five months he grasps objects with thumb and forefinger. At five months the child holds the bottle with two hands, by six months the child holds bottle with one hand.

LANGUAGE

COGNITION

SOCIAL

of the distinctiveness of his fingers and hands. By six months he senses the relationship between his hands and the objects they manipulate. During this period, he deliberately imitates sounds and movements.

socializing is disturbed, and if his toy is taken away.

Cultural: His interest in feeding decreases because of increase in socializing. By five months he takes solids well. Can be introduced to cup. By six months shows interest in wanting to feed self. During this period, he generally sleeps through the night but is up at dawn. Daytime naps decrease in duration. Is awake approximately twelve of twenty-four hours.

THE SEVENTH THROUGH THE NINTH MONTH

Large: Moves well. Crawls, pulls self to stand, sits. By eight months he crawls backward and forward. Also moves forward by sitting and lunging on buttocks, or by standing and grabbing on furniture. By nine months he can turn around when crawling and crawls upstairs. Also at six months he can stand alone, and may stand up from sitting position without pulling upon furniture. At seven months the infant may get self to sitting position, by eight months he sits alone and enjoys bouncing on buttocks. At nine months

Active: Vowel and consonant sounds occur at random. At seven months he tries to imitate sounds and may say dada and/or mama. At eight months he babbles continuously - even when alone. Begins to put adult intonations on babbling. May begin to label objects in imitation of its sound e.g. choo-choo. By nine months he uses dada and mama as specific names.

Passive: He listens to own vocalization and those of others. By seven months he turns head in response to

Interest in detail apparent. Child concentrates full attention on what he is doing. Examines objects in detail - explore concepts such as "in and out," "open and close," "behind and in front." Enjoys noise making objects - bells, keys, etc. By eight months has developed the concept of object permanency - know that an object exists even when it is not in his view. He changes dimensions of objects by partially covering his eyes or the object. By nine months, the infant begins to show fear of heights - e.g. if a table is

Personal: Explores own body with mouth and hand. Pats, smiles at, and tries to kiss self in mirror. By nine months he perceives others as separate people - especially mother and father.

Interaction: Fear of strangers increases. Is clearly attached to mother, follows her around. Desire to be included in social interaction increases, he shouts for attention. He shows likes and dislikes and differentiates between friendly and angry talking. Begins to initiate social play. Enjoys games such as

MOTOR

LANGUAGE

COGNITION

SOCIAL

THE SEVENTH THROUGH THE NINTH MONTH (continued).

he sits from a standing position. By seven months he holds two objects, one in each hand and may bang them together. By eight months he can pick up very small objects e.g. string. By nine months he can build a tower of two blocks.

familiar sounds: his name, telephone. By nine months he responds to words other than his name e.g. no-no, and may follow simple commands e.g. "Go get your toy."

made of a transparent material he will not get on it. Memory is increasing by nine months, he remembers activities from a previous day. Begins imitating people and behaviors even when they are not within his visual or auditory range. Becomes aware of the relationship between his body movements and those of others.

By nine months he anticipates rewards for task completion. He solves simple problems e.g. pulls string to secure toy. Begins establishing differences between one and more than one, sizes, shapes. Combines bits of behavior to perform new task. At nine months he shows symbolic thinking by getting involved in role playing.

pat-a-cake.

Cultural: Wants independence in feeding: holds bottle, manipulate cups, can finger feed self. By eight months he may have trouble sleeping. By nine months he begins to fear baths.

TEN THROUGH TWELVE MONTHS

Stands well. Side-steps along furniture. Walks holding two hands, by twelve months most babies can walk independently. Climbs up and down steps on all fours. Climbs in and out of chairs. By twelve months climbs in and out of crib and play pen. Begins to make swimming like movements in tubs. Begins to use crayons.

Active: Learns words and gestures, says no and shakes head, waves bye-bye. By the twelfth month sounds that are more specific to native language increases. Child also becomes aware of the expressive function of language e.g. says "damm" at appropriate times. Practices words and sounds that he knows.

See individual objects as separate from others. Continues to learn about properties of objects e.g. crumples paper, listens to watch tick, points at objects. By twelve months, the child unwraps toys, looks for toys under pillow, etc. He searches for hidden objects even if he has not seen it hidden but remembers where

Personal: Shows moods: looks sad, happy, hurt, uncomfortable, angry. Also recognizes these moods and emotions in others. Shows preferences - likes music. Shows assertiveness especially among siblings.

Interaction: More sensitive e.g. cries if other children get attention. Increases dependence

MOTOR

TEN THROUGH TWELVES MONTHS (continued).

By twelve months shows hand preference. Can push as well as pull objects, can point. Begins to undress self at twelve months.

LANGUAGE

Passive: Listens with interest to familiar words. Understands and obeys simple commands and directions. Recognizes words as symbols for objects e.g. airplane, sky, doggie.

COGNITION

he saw it last. Begin elementary classification: e.g. associates airplane and kite as flying objects. He studies displacement of objects - stack things, places and removes them from containers, rotates and reverses objects. Increasingly imitates behavior e.g. rubs self with soap, feeds others. Experiments with different acts, tries new ways to do old things. Begins to learn concepts of matching, sorting, nesting, stacking. Increasing association of properties with things e.g. meows for kitten, bow-wow for dog. Looks at pictures in books etc. with interest. Discriminates between personalities - may trust different people differently. Role play increases appears to mentally process actions and events before acting them out.

SOCIAL

on mother: tests limits: tries to get his way by protest. Reacts sharply to separation from mother. Shows signs of regression, becomes increasingly negative. Temper tantrums begin - refuses nap, food, etc. Shows definite preference to some people. Plays parallel to but not with other children. May sometimes give up a toy upon request.

Cultural: Feeds self whole meals and insists on it. Eats three meals a day. May have trouble sleeping - needs one afternoon nap. Helps dress self.

TWELVE TO EIGHTEEN MONTHS

Constant motion. Child very active - walks crawls, runs, hops. (Needs adult to look out for his safety: may touch hot stove, step off curve.) Learning to throw and tosses things indiscriminately: Use the whole body while throwing. More adept at climbing stairs, they also climb on to tables, etc. Hand eye coordina-

Babbling sounds start to form into words. (Note that children usually do not acquire the skills of walking and talking simultaneously: some children learn to talk first, others learn to walk first). Can usually say between 4 - 10 words clearly. Additionally, children at this age understand more words than they can say.

Becoming more autonomous: they can accept or reject demands: they say "no" quite emphatically. Experiments, explores and investigates wants to touch, taste, feel etc, open drawers and cupboards, overturn trash cans. Attention span still short but they can get involved in activities that interest them. Stimulus - re-

Temper tantrums on the increase: biting kicking, hitting, breath-holding, head banging. (Normal means of self-expression.) Becomes increasingly assertive. Play is still parallel. Waver between dependence and independence. May go through periods of excessive clinging. Can get off shoes and socks with ease. They can put on

MOTOR

LANGUAGE

COGNITION

SOCIAL

TWELVE TO EIGHTEEN MONTHS (continued).

tion still not totally developed:
child can use large pegs and
peg boards. Small motor activities
should be encouraged.

sponse period: child is action
bound in ability to learn from
his environment - he learns
by acting upon the stimulus:
he does something to an object
and something happens: develops
an understanding of
cause and affect.

shirts, struggle with trousers
usually get both legs in one
opening. Pullovers are difficult
to manage. Their efforts at
self-help should be rewarded.
Enjoy feeding self alone, most
food lands on self and floor.
Nap once a day and sleep
through the night. Usually
ready for bed around nine.
Develop fears: the dark, sleeping,
sudden noises e.g. sirens,
vacuums, etc. Expresses fear
by crying and clinging - need
reassurance. Have difficulty
sharing.

EIGHTEEN MONTHS TO TWO YEARS

Walking skills increasing: some
can walk backwards. Still very
active: runs, walks, crawls,
climbs, climbs steps, opens and
closes cupboards and drawers,
pulls, pushes, bangs, throws,
dumps, pours: sand and water
play a favorite. Music gets
positive, alert responses. Some
two year olds try to dance.
Small muscle coordination
much more developed: can put
pegs in pegboard, can slip
rings over pegs in pegboard,
can pick up small objects,
can turn pages in a thick book,

Says 10 words including name.
Identifies 2 or more common
objects on cards or books.
Can carry out two direction
commands: one at a time -
e.g. "Take the ball." "Give
it to mommy." Uses two
word sentences, e.g. "go home"
Can repeat simple one and two
word ~~syllables~~ ^{words}. Can ask for a familiar
object by naming it e.g.
"cookie", "milk."

Understand concepts of in and
out, big and little, up and down.
Can associate words with meaning
e.g. refrigerator with milk.
No conception of past or
future: everything is in the
present. Still very egocentric:
think they have complete control.
Concepts such as one to
one correspondence, elementary
classification and seriation
are being developed. Identifies
many familiar objects by
pointing. Can identify many of
his own body parts. Experiments
with toys e.g. uses

Becomes attached to special
toy: carries around and hugs
this toy. Pulls toys on string.
Temper tantrums still very prevalent.
Increasing need for independence - still wavers
between dependence and independence.
Very little self-control.
Self-help skill increasing:
still needs help dressing
but can put on, with trial
and error, socks, shoes, shirts
and undergarments. Feeding
still messy but encourage
attempts at self-help. Play is
still parallel: children enjoy

MOTOR

LANGUAGE

COGNITION

SOCIAL

EIGHTEEN MONTHS TO TWO YEARS

can build a tower of as many as four to six blocks. Scribbles spontaneously and imitates a writing stroke. Enjoys using crayons. Can catch ball, can kick ball clumsily.

stick to get object that is out of reach.

each others' companionship even if they don't play together. Still have a great deal of difficulty sharing.

TWO YEARS THROUGH TWO YEARS & SIX MONTHS

Usually climbs steps with two feet on the same step. Some try climbing step one foot at a time while holding on to the railing. Can kick a ball. Can squat and balance. Runs well - no falling. Builds a tower of 6 to 8 cubes high. Can turn page singly. Makes small marks with crayons. Imitates vertical and circular strokes. Awkwardly snips with scissors. Can master three to four piece puzzles.

May know as many as two hundred to two hundred and fifty words. At this age language ability varies - some may have a lot less than a 200 word vocabulary. Can understand 200 words. Uses two to three word sentences. Uses pronouns: I, me, you: but not always correctly. Adult type vocal intonations are often used: asking, scolding, telling, etc. Can carry out up to four simple directions. Can name 10 - 15 different objects accurately.

Can line up blocks upon request. Can isolate one object from group of objects. Shows interest in learning to count but at this stage it is mainly parroting. His time frame begins to extend to include a past. Can usually deal with one property of an object: a teacher is a teacher - she cannot be a teacher and a mommy. Can follow routines: routines, however, should be kept clear and simple. Understands some prepositions: on, under. Repeats a two digit sequence. Can name several familiar objects and pictures.

Very assertive in likes and dislikes. Often refers to self by name. Mimics mother often: role plays, attempts to help with household chores, talks on the telephone, etc. Play still mostly parallel. Can take off, as well as put on, most articles of clothing. Usually a good time for toilet training: sphincter muscles are developed. Skills of feeding self are increasing.

MOTOR

TWO YEARS & SIX MONTHS TO THREE YEARS

Can jump on both feet. Can balance self on one foot. Can walk on tip-toes about two to three steps at a time. Attempts to pour liquids, is successful if container is small (child size). Can fold a single sheet of paper after initial demonstration. Imitates horizontal and vertical lines with crayon. Uses crayons freely - may persevere. Scribbles with crayon or pencil. Holds crayon and pencil with thumb and opposing finger. Can turn single pages of a book. Enjoys painting: uses wrist movement in painting.

LANGUAGE

Can identify objects by use e.g. "Show me what we cook on." Easily combines three or four word sentences e.g. "Baby go to sleep." Vocabulary still ranges between 200 to 250 words.

COGNITION

Can seriate when asked to put things in order. Classifies by one property e.g. big versus little. Can recognize his own picture as well as pictures of immediate family members. Can understand the concept of "another." Can understand simple questions about familiar objects e.g. "What is your name?" "Where is the doll." Begins to understand the concepts of past and future as well as present. Thinking still essentially egocentric. Understands the difference between "in" and "on." Can identify part of an object and see it as a whole. e.g. see part of a car and identify it as a car.

SOCIAL

Can put things in the proper place. Can play interactive games. Enjoys finger plays. Should have mastered toilet training and verbalize toilet needs well, and can wash and dry hands. Makes attempts at cooperative play: make attempts at sharing, showing favorite toy. Engages in meaningful role play. Can separate from mother after initial trauma.

THREE TO THREE YEARS & SIX MONTHS

Begins to ride a tricycle, slide, pump a swing. Enjoys doing stunts on jungle games. Uses crayons freely and well. Attempts to draw simple figures. Can walk in a straight line. Can jump from the bottom of a step. Can walk up stairs like an adult. Can throw ball overhead. Can catch bounced ball. Can hop on one foot. Can drive pegs in with hammer. Can pick up small objects with one eye closed. Threads large beads. Traces diamond shapes. Can copy circles, cross.

Can give first and last name when asked. Can give age. Can give sex. Active vocabulary 300 - 400 words. Receptive vocabulary 400 to 700 words. Can sing simple songs.

Begins to understand concept of numeration: oneness. Uses pronouns and verbs frequently and appropriately. Discriminates large and small, up and down can rote count consecutively to five. Has a future orientation. Begins to understand sequence. Beginning to develop ability to solve problems. Still unable to handle more than one variable or property of an object.

Temper tantrums decrease. Instead of acting out may verbalize "I don't like you." Enjoy sand and water play: have a therapeutic effect. Enjoys cooperative play. Still has difficulty sharing or taking turns. Can dress self with some help. Shows affection for peers and younger siblings.

THREE YEARS SIX MONTHS TO FOUR YEARS

Can put seven piece puzzle together. Can put 15 piece toy together. Adept at using small pegs. Imitates building of bridge with three cubes. Copies 5 block train. Threads medium sized beads. Can build vine tower block. Rides tricycle, pumps swing, hops on one foot two or three times. Can unbutton buttons. Can close and open zippers. Can pour well, can spread butter on bread. Can jump, walk and run to music.

Receptive vocabulary 500-1,000 words. Active vocabulary 400 - 600 words. Asks many questions: What? Where? Why? Who? Talks to self in long monologue with content continuity. Uses adverbs and adjectives. In a limited way, relates experiences and describes activities. Can whisper coherently. Can recite a popular nursery rhyme. Enjoys short stories, likes being read to. Speaks in 4 to 6 word sentences.

Names basic shapes: circle, square, triangle. Understands concept of longer, shorter, larger, smaller. Uses concepts of me and my appropriately. Understands concept of twoness. Can accurately match pictures to numbers up to three. Attention span increases. Describes what is happening in a picture book. Can rote count up to 10. Can name approximately six colors.

Attempts to help with household tasks. Play is increasingly more cooperative and social. Enjoys playing with small group. Understands taking turns. May have special friend. Dresses and undresses self completely with minimum adult help. May test limits with mommy, especially in new situations. Can put away own toys etc.; knows proper place. Uses fork and knife appropriately. Sleeps all night but may get up in the middle of the night and get in their parent's bed. May wet-bed at night.

FOUR YEARS TO FOUR YEARS SIX MONTHS

Balance is good. Can carry liquids without spilling. Can skip smoothly. Can hop on one foot for longer periods. Can touch toes with knees straight. Walk downstairs one foot at a time. Stands on one foot 4 - 8 seconds. Copies shapes: triangle, cross, square. Climbs over boxes; barrels. Enjoys ladder, jungle gyms slides: experiments with various ways of using jungle gyms and slides. Can cut and paste. Can sew cards with large holes using large needles.

Chatter as they work, describing, in complete sentences what they are doing. Active vocabulary approximately 1,000 - 1,200. Receptive vocabulary 1,500 - 2,000 words. Are fascinated by words, using all sorts of silly words and laughs about it. Uses profanity frequently - do not know the meaning of the words. Uses words to express feelings. Listens eagerly to stories. Uses language to describe objects.

Knowledge of spatial relations: between, in front of, beneath, upside down, right side up, near. Can perform linear order - put in line or row - on a group of 9 objects. Knowledge of temporal relation: can sequence group of 3 - 4 cards if sequence depicted is irreversible. Understands the concepts of begin and finish. Uses language that depicts knowledge of past tense: "I just ate." Understands concept of threeness. Developing ability to problem solve and reason. Very curious - asks questions, explores objects. Identifies simple materials that things are made of. Understands physical properties of objects: Will it burn? Sink? Float? Distinguishes differences in many shapes: triangle, square, hexagon, octagon.

Combines imitation and make-believe in socio-dramatic play. Plays cooperatively with other children. Washes and dries face and brushes teeth correctly. Friends and peer groups are very important: have special friends. Get into disagreements with friends and peer groups: name calling and fighting is used. More independent but need frequent adult reassurance. Sex typing established. Girls show increased interest in dolls, boys in cars and trucks. Most still need an afternoon nap, and sleep through night. well. Seeks adult praise and recognition. Begins to show interest in sex differences and reproduction.

MOTOR

LANGUAGE

COGNITION

SOCIAL

FOUR YEARS SIX MONTHS TO FIVE YEARS

Can follow simple patterns for folding paper. Thread small beads. Can build detailed block structures. Easily uses scissors but does not necessarily follow lines. Can walk up and down stairs, one foot per step without real support. Can jump one to two feet off the ground. Can lace shoes - begins to make attempts at tying. Can copy simple patterns with blocks, beads, etc. Can button and unbutton buttons. Child has general motor control but small muscles not as fully developed as large ones.

Can give full name of self, parents, siblings and peers. Interacts verbally with one other person. Gives age and birthday. Answers and asks questions freely: asks complete questions. Can give simple explanations when asked simple questions. Uses complete sentences. Understands five prepositional directives: on, under, in, in back or in front of, and beside. Language development still very rapid: vocabulary over 2,000 words.

Identifies similarities and differences about physical properties of objects. Identifies varying habitats for animals: land, water, trees. Distinguishes size differences: small, large. Knows less common social roles: chef, artist. Increased use of abstraction: does not always need real object. Identifies superlatives: largest, tallest, longest. Classifies objects by function: thing you build with. Can count out up to 8 objects from larger group. Performs linear inverse on group of three objects. Reproduce patterns with blocks or beads. Can verbalize position in space: "I am beside Kim." Identifies common object when only part is visible. Knows temporal order of morning, afternoon, evening. Understand seasonal concepts in terms of events: holidays, weather, birthdays.

Increased ability to delay gratification: take turns and share. Shows increasing regard for other people's feelings. Seeks approval and help from parents. Socio-dramatic play includes more abstraction. Understands use of several parts of the body. Prefers to play in group, still has special friend.

FIVE YEARS TO FIVE YEARS & SIX MONTHS

Skips using feet alternately. Raises directly to standing position. Can bounce ball continuously, learning to catch and throw balls. Can hop for 2 - 3 yards forward on each foot. Is learning to jump rope. Plays "jumping jacks." Can walk for short distance on tip-toe. Can sit for long periods. Can draw 6 - 7 parts of a man: head, trunk, arms, legs, eyes, nose, mouth. Can thread large eye needle. Can cut with scissors follow-

Interacts verbally with one person or small group. Interested in meanings of words; asks questions. Can define simple words. Identifies primary colors. Tells stories about his activities. Can generate lists of related words. Extends his repertoire of superlatives: softest - hardest; roughest - smoothest; bumpiest, loudest. Names coins: pennies, nickles, dimes, quarters. Enjoys listening to stories. Can recognize several words on sight

Attention span increases to about 15 minutes. Identifies variety of animals and objects from their pictures. Counts up to ten accurately. Draws a recognizable man with appropriate body parts. Recognizes and names common coins. Shows increasing problem solving ability. Loses some of his egocentrism: knows that there is another point of view and may adjust his behavior according to feedback from others.

Can print some letters - usually those in his name first. Recognizes more letters than he can print. Plays some competitive games. Cooperative play is on the increase. Cleans up after play with no coaching. Assertive in play: can be a follower as well as take leadership roles. Knows increasing number of social roles. Enjoys dramatic play. Feeds self well. Spreads with knife - has partial success. Enjoys bathing self: may need

MOTOR

FIVE YEARS TO FIVE YEARS & SIX MONTHS (continued).

ing lines. Handedness is well established. Makes attempts at tying shoes with some success. Eye hand coordination is markedly improved. Sensory-motor equipment is not usually ready for reading. Activity level high.

LANGUAGE

but is not ready to read yet.

COGNITION

Uses language that depicts knowledge of future as well as past and present tenses. Skill with sequencing increasing: can sequence a group of four or more cards. Uses combination of comparative and superlatives in ordering: tall, taller, tallest. Can seriate at least 7 sticks of differing heights.

SOCIAL

some help. Can brush teeth well. Interest in animals on the increase: enjoys pets. Usually has complete sphincter control: bed wetting usually reduced to an occasional accident. Enjoys being given some responsibility.

FIVE YEARS SIX MONTHS TO SIX YEARS

Can twiddle thumbs. Can print numbers 1 - 5: may need some help. Can reproduce letters and simple words but are not yet ready for writing. Can snap fingers. Can complete two or more gross motor activities simultaneously after being given directions e.g. lie down, put your feet together, lift them up straight and put them down slowly. Can jump like a frog using both hands and feet for support. Eyes not yet mature - tendency toward far sightedness. Large muscles are still better developed than small ones. Can pour and carry liquids well. Enjoy blocks, paints, clay, tools, puzzles, songs, and rhythms. Some may be ready to learn to read, but many are not: don't push.

Use language fluently and correctly. They pronounce words clearly and are easily understood. They enjoy carrying on conversations and love to tell stories. They recount incidents in sequence. Able to put fears and anxieties into words.

Attention span still relatively short, however, children may become absorbed in a project that satisfies their growing interests. They often work with a goal in mind. Ready for simple basic principles of mathematics and science. Beginning to understand temporal relationship: past, present and future. Can combine ideas and concepts and use for problem solving. Beginning to understand cause and effect: this is a sequential step in the process of logical thought. However, they are not yet capable of understanding abstract ideas - need variety of concrete experiences.

Can dress and undress self alone. Can tie shoes. Understands the need for rules and fair play. Plays well in small groups and understands rights of others. Can understand table manners but needs help enforcing them. Can use knife and fork well but enjoys eating with hands. Level of maturity is inconsistent: often less mature at home than at school. Enjoys other children and want to be with them. Though vigorous in activity, children at this age are less restless than before and activity usually has a definite direction. Quite independent - enjoys doing things by and for themselves. They enjoy doing simple errands. Sense of morality developing. Child knows right from wrong.

MOTOR

SIX YEARS TO SEVEN YEARS - (A Period of Transition).

Physical growth is slower than before. Large muscles still better developed than small ones. Activity level still high - need ample opportunity for physical activity. They learn through activity - involve all parts of their body: enjoy jumping, running, climbing, clay, water play etc. Eyes are still not yet mature in size or shape - hence hand-eye coordination still not fully developed. Learning to bat ball and jump rope.

SEVEN YEARS TO EIGHT YEARS - (A new phase of development).

Physical growth slow and steady. Hand-eye coordination is improving, as a result they are better able to use their small muscles. Reading skills improved: many are ready to read. Writing skills are improving. Still active, but more likely to balance activity periods with quiet play. Enjoy climbing, swinging, balancing, riding, bicycles, jumping rope, painting, clay modeling, carpentry etc. They are quite skilled at many of these activities.

LANGUAGE

Enjoy telling stories: do so with gestures etc. They are very imaginative and often add their own ideas to stories, etc.

Very talkative, prone to exaggerate. Enjoys stories: listening and telling. Likes to read simple books. They carry on vivid conversations. Express feelings with words easily.

COGNITION

Attention span is still relatively short. Learns best through active participation and concrete experiences. Eager to learn, they ask a lot of questions.

Although capable of some abstract thinking, they learn best through activity and through concrete experiences. Basic understanding of time and rudimentary values. Attention span has increased. Better understanding of temporal relationship and sequence. Well grounded in reality, want to know facts about everything. Show interest in science, mathematics. Understand concepts of time and how to tell time. Understand monetary concepts and the value of money.

SOCIAL

Generally self-assertive and aggressive. Wants to be first. Not very cooperative. Regression from five years old. Group activities are popular. Boys and girls interests beginning to differ. A turning point: step beyond the family circle into the large world of the school and community. Dramatic play still very popular. Like responsibility and enjoy doing chores at home. Seek, enjoy and need adult praise and recognition.

Sensitive to feelings of both children and adults. Especially dependent upon adult approval. Tendency to imitate adult behavior. Interest of boys and girls diverging - less playing together. Very concerned about moral values - right and wrong. They will stand up for their rights and the rights of others. Difficult to take turns. Enjoy dramatic play. Like to be independent, enjoy leadership roles. Can take care of most of their physical needs - can bathe and dress self, tie their shoelaces and brush their teeth.

EIGHT YEARS TO NINE YEARS - (Enjoy New Experiences).

Eye-hand coordination well developed. Writing skills are improving, as are skills with manipulative tools, toys and art materials. Large muscles are still developing. Children need continued opportunity for movement and active outdoor play; running, climbing, swinging, riding, etc.

Enjoy reading: comic books hold a particular attraction for children of this age. Fairy tales, humor, animals are also of particular interest. Enjoy discussions and telling stories: more concerned with real facts than they were before.

Great interest in collection of all kinds: can learn many concepts through collections. Understand the purpose of money and to some extent its value. Better understanding of time. They can tell time and understand temporal relations. Understand concepts of life and death. May seem preoccupied with death. Show increasing interest in babies: delight in them, are fascinated by them, and want to take care of them. Still confused about the birth processes: ask questions about differences between boys and girls, and request detailed information about conception and birth. Awareness of other parts of the country and world increasing. No longer only concerned with own neighborhood. Notice racial, national and international differences. Can accept differences in selves and others.

Dependent on parents for praise, recognition, encouragement and emotional support. Enjoy group games, especially active sports like baseball, football and soccer. Try to learn the rules of games and insist that the rules are followed. Dramatic play is still popular and many girls are still very involved with dolls. They want best friends but quarrel and argue frequently. Also seem to enjoy enemies. At this age boys and girls are pulling apart in their activities and interests. Sometimes they gang up against each other and call each other names. Often want to belong to a group - establish gangs and clubs. This provides a feeling of security. Frequent dramatic play.

- 196 -

NINE YEARS TO TEN YEARS - (Growing Individual Differences).

During this year girls who mature early may reach the growth plateau that precedes the adolescent growth spurt - some may begin menstruation. Eye hand coordination is good. These children are usually very skillful with their hands. Still very active, enjoy activity and rough and tumble play.

Talk increasing - carry on long conversations with their friends (groups or gangs) - make plans, discuss activities. Great individual differences in reading: many are great readers, others may still be unable to read. Ask lots of questions on various subjects and expect plausible realistic answers.

Attention span is greatly increased - capable of sustained attention in activities that interest them. They have original ideas and interests and are capable of carrying them out, as long as they are of interest. Very interested in and conscientious about school work. Interests in the world at large increasing - they enjoy pen-pals, ask questions about other peoples and

Sex differences are increasing. Often perfectionists: very critical of their performance, take pains to make corrections. Enjoy competitive games: relays, etc. - sometimes competition gets out of bounds, winning is very important. Having friends and belonging to a group are important. Copy each other in clothes, mannerisms and behavior. Like to take responsibility to com-

MOTOR

LANGUAGE

COGNITION

SOCIAL

NINE YEARS TO TEN YEARS - (Growing Individual Differences)

world conditions. Interests in own country and the people in the various states are high - good time for social studies. Great experimenters - interest in science increasing - they love to complete scientific experiments. Less egocentric - realize that there are points of view and opinions other than their own. Also realize that parents and teachers do not have all the answers.

plete tasks and run errands. Like praise and recognition for things they have done but do not like to be praised in public. They will accept well justified criticism and punishment, but will be very outspoken if they do not think that the criticism or punishment is deserved. Increasingly developing sympathy and loyalty to others.

TEN YEARS TO ELEVEN YEARS

Both small large muscles are well developed. Coordination is good. They enjoy participating in rigorous activity e.g. climbing, running and active sports. For many ten year olds reading is a favorite activity. They are also interested in creative art projects can spend many hours completing a project. Eyes are well developed, they are almost adult size.

At this age children spend a lot time in talk and discussion. They are often outspoken and critical of each other and adults. Wide variances in reading ability are evidenced at this time. Many children show a great interest in books at this time.

Active and intense interest in world affairs, politics, social justice and injustice. Social studies can become the core of the curriculum. Enjoy work on projects, developing ideas and implementing those ideas. They are still interested in collections - sometimes collections develop into permanent interests. Beginning to develop the capacity for abstract thinking. Very concerned about God; life and they ask detailed probing questions and expect to receive correct, honest answers.

Able to take care of selves - can deal with long trips away from home. They want to feel responsible: enjoy being given chores to complete and will do a thorough job. Still form unisexed groups. Social activity is a central concern. At this age children often join and/or form social clubs or groups, e.g. girl scouts or boy scouts. They are loyal to the group and are willing to share responsibilities. Having a best friend is important. Growing in self-control. They don't cry as often as before. They often flair up and call each other names getting their feelings hurt, but they do not harbor grudges. They still enjoy participating in family activities. They are careless about cleaning their rooms etc. At this age girls are generally more mature

MOTOR

LANGUAGE

COGNITION

SOCIAL

TEN YEARS TO ELEVEN YEARS (continued).

than boys. While there may be some social mixing in planned activities, in spontaneous activities, boys and girls usually stay separated. Age of hero worship: often day dream about things they want to do with their hero or heroine. They are increasingly concerned with right and wrong and are very sensitive to unfairness, cheating, lying and stealing.

PRE-ADOLESCENCE & ADOLESCENCE - (11 - 16 years)

As suggested by Robert L. Havighurst, the developmental tasks of the adolescent and preadolescent are:

1. Achieving new and more mature relations with age - mates of both sexes.
2. Achieving a masculine or feminine social role.
3. Accepting one's body and using and protecting the body effectively.
4. Achieving emotional independence of parents and other adults.
5. Preparing for marriage and family life.
6. Preparing for an economic career.
7. Acquiring a set of values and an ethical system as a guide to behavior.
8. Desiring and achieving socially responsible behavior.

In helping the child accomplish these developmental tasks, parents and teachers must work in harmony. The preadolescent and adolescent years are difficult ones for all concerned. It is the transition period between childhood and adulthood. Many psychological and physiological changes are occurring and children need help in understanding and adjusting to those changes. The following paragraphs outline some of the changes that occur during these periods and the behaviors that occur as a result of those changes.

THE PRE-ADOLESCENT (11 - 13 years)

These are the transition years between childhood and adolescence. The time span for this occurrence is generally between the ages of 11 - 13. At this time many children begin the cycle of puberty accompanied by the physiological and psychological changes. When the pubertal cycle begins children will show changes in growth patterns, attitudes and behavior.

The age of maturation at puberty is genetically determined and cannot be delayed or hastened. The hypothalamus in the brain starts the increased production of the pituitary and sex hormones which starts the cycle of puberty. The first noticeable bodily changes occur one to two years before the actual occurrence of puberty.

There is a wide variation in the age at which the pubertal cycle begins and the rapidity of the occurrence of the stages within the cycle. Girls usually reach puberty two years before boys. Most girls begin the pubertal process between ten and eleven and boys between twelve and thirteen. The age range, however, is very wide. Girls may menstruate between ten and sixteen and boys may mature between twelve and sixteen.

Boys and girls experience the "growth spurt" during the pubertal cycle both in terms of height and weight. This growth usually tapers off in girls after menstruation. The growth spurt in boys may or may not precede sexual maturity. Many parents and children become unduly concerned about the weight gain during puberty. However, unless the child has been overweight during early childhood, or unless over-eating or emotional problems are involved, there is usually no cause for alarm.

Muscular and organic growth occur spontaneously with growth in height and weight. Since this growth occurs in girls before boys there is approximately a two year period during which girls are heavier, taller and physically and emotionally more mature than their male peers. Growth in all parts of the body does not occur simultaneously. This may cause self-consciousness on the part of the child, and clumsiness.

Parents and teachers need to become aware of the physical and emotional changes that occur during puberty. With knowledge and awareness they are better able to help the child through this period of development.

During this period children are afraid, confused and often feel insecure. Their demonstrated behavior fluctuates between being hostile and negatively aggressive to being very pleasant and cooperative. They need adult support and encouragement. This is a trying time for adults (parents and teachers) and children.

Parents should ensure, during these years that children are given honest factual information about the physiological changes their bodies are going through and about sex, reproduction, the birth process, and the sexual roles of males and females. It is important that children get this information from a trusted adult in an open and honest

fashion. The information should be presented in a relaxed way so that children can think of their sex organs as a natural part of their bodies and not an object that needs to be feared, hidden or upon which special attention needs to be focused. In addition, parents should make special attempts to develop an open, trusting relationship with their preadolescent children so that children feel free to ask questions and share information from their parents. If this kind of relationship is not developed, the chances are that children will obtain the information, in a thwarted fashion, from their peer groups.

Peer groups are important during this period. Acceptance in the peer group is more important to preadolescent children than their relationship with parents, teachers and siblings. Male, female social activities and relationships should not be pushed at this time. Most children are not ready for it, and prefer developing such relationships at a slower pace. A precocious social life deprives children of the pleasures of childhood.

This is also an age during which delinquent behavior can develop rather easily. Boys and girls have outgrown the children games. They have a lot of free time and often succumb to group pressures. Parents and teachers should help plan constructive activities for the preadolescent. Suggested activities may be organized - sports, boy scout and girl scout groups, music lessons, swimming meets, etc.

THE ADOLESCENT (13 - 16 years)

The major problem during adolescence are the great variances in physical development. Some of the children are still in the late childhood stages of physical growth while others are physically mature. By the age of 14 or 15 most girls have matured physically, while most boys are still in the preadolescent stage.

During adolescence great emphasis is placed on physical appearance. Many feel uneasy or dissatisfied with their bodies. The Western cultural image of small, thin girls and tall strong boys tends to make this dissatisfaction, insecurity and self-consciousness even more real. During this period adults need to provide constructive help and reassurance, rather than criticism.

Adolescents experience sexual drives and emotions that they had not experienced before. Many of these feelings they are not mature enough to really understand. They often lack the proper judgement that should accompany the ability to reproduce. Parental relationships are important at this time. Adolescents need help and guidance if they are to develop sound judgement and a responsible attitude about sex and their own sexuality. Often adolescent girls are physically more mature than their male peers. This fact means that adolescent girls are sexually attractive to older boys. Not being able to understand their emotions or their own sexuality, adolescent girls are often quite seductive. Parents need to be aware of these facts and exercise proper precautions and limitations.

Drug experimentation and addiction, delinquency, alcohol intake and alcoholism, pregnancy, prostitution and venereal disease are all serious problems of adolescence. Parents and teachers need to be aware of these problems and deal with them openly and honestly. Adolescents need to be informed of the existence of these problems, the effects of group pressure, and the dangers's involved. While some restrictions and limitations need to be placed on adolescents, parents must allow a certain amount of freedom. Parents must show trust and confidence in their children, and must be available to provide the needed support during these trying years.

Adolescents are very egocentric. Adolescence is the period during which children are trying to establish their own identity. The foremost question is, "Who Am I?" As they become more self-assured and more mature they are able to relate freely to other people and develop sincere, lasting relationships. The peer group is important. Adolescents gain reassurance and security from belonging to a group. Problems may exist, however, because adolescents may do stupid things in their efforts to belong to a group. Many children who would not experiment with drugs as individuals will do so under group pressure. Conformity to the group is of utmost importance.

During adolescence boys tend to be more loyal to their friends than girls. Girls tend to be more "cliquish" and can be very cruel to those who do not meet the standard for acceptance into the clique.

The adolescent years can be a very stimulating time intellectually. Interests that develop at this time may lead to a career. There is marked growth in cognitive development during this period. Children are able to look at things realistically and are developing the capacity for logical thought. They are able to handle abstract concepts and are interested in the abstract. This is also a period during which they question adults and will argue and debate their point of view. In some children, however, academic pursuits give way to social pursuits and emotional problems. Individual differences in academics are also prevalent during adolescence.

The changing moods of the preadolescent continues during adolescence. The adolescent may be happy, out-going, self-confident and cooperative one minute and despondent, hostile, shy, and self-doubtful the next minute. They fluctuate between being generous and selfish, between wanting to be with friends and wanting to be alone and demanding utmost privacy. This period is a difficult one for both parent and child. Both parties need support and encouragement, but often receive criticism and condemnation.

B. METHODS OF INSTRUCTION

Lectures and discussions should be accompanied with lots of opportunity for practical experience. Students should be able to observe children and work with them under close supervision. Child development is a detailed course of study. Information should be presented slowly and in a number of ways. Clinics, schools, child development centers and hospitals are places that can provide the trainee with practical experiences. Most of these institutions need and welcome the additional help that students could provide.

C. METHODS OF EVALUATION

Paper and pencil tests: both objective tests that assess factual knowledge, and essay tests that are geared to assessing application of factual knowledge are recommended. Charting observations of children as well as teacher observations of the student are good forms of evaluation. Self-evaluations and peer-evaluations are also helpful.

D. LIST OF REFERENCES

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Film Strips:

- Understanding Early Childhood Series.
Set 1: The child's relationship with the family.
Set 2: The development of feelings in children
Produced by Parents Magazine Films Inc., 52 Vanderbilt Ave., New York, N.Y. 10017
- Working with children: A Commitment to Caring.
Set 1: Understanding the responsibilities of child care.
Set 2: Encouraging healthy development in children.
Set 3: Dealing with daily situations.
Set 4: Cooperation among staff, family and community.
Produced by Parents Magazine Films Inc., 52 Vanderbilt Ave., New York, N.Y. 10017

OBJECTIVE TWO

Demonstrate the acquisition of a basic understanding of Piaget's theory of cognitive development.

A. DISCUSSION

Included in the following pages is a brief synopsis of the Piagetian theory of cognitive development. The synopsis is merely intended to give the reader an elementary view of some of Piaget's work. It is not a complete review, and the reader is cautioned not to interpret it as such. The list of resources, given at the end of this section, provides more detailed information on the Piagetian theory.

B. INTRODUCTORY REMARKS

Jean Piaget was born in 1896 in Switzerland. At age 18 he received his baccalaureate degree from the University of Neuchatel in Switzerland, and at 21 he received a doctorate in the natural sciences from the same school.

Piaget's educational background is in biology. As a result of his work in biology Piaget conceptualized intellectual development from a biological standpoint. He believes that cognitive acts are acts of organization of and adaptation to the perceived environment. This does not imply that cognitive behavior can be attributed solely to intellectual development. Rather, Piaget feels that some biological concepts are valid for looking at cognitive development.

C. JEAN PIAGET'S THEORY OF COGNITIVE DEVELOPMENT

Cognitive development, according to Piaget, begins at birth and continues throughout life. Although the child is not born thinking, the behaviors that occur from birth are prerequisites for later cognitive development.

SCHEMATA

Piaget believes that the mind has cognitive structures which enables a person to intellectually adapt to and organize the environment. Piaget calls the structures schemata. At birth a child has few schemata. As the child develops, the schemata broadens, becomes more differentiated and more adult.

At birth schemata are reflexive in nature - the child engages in simple reflexive motor activity e.g. sucking and grasping. Shortly after birth the infant begins to differentiate: he sucks milk producing objects and rejects those that do not produce milk. These differentiations are precursors of later mental development. This ability to differentiate and to make distinctions become more numerous and refined as the child matures and develops. As the child grows schemata changes. Piaget attributes the change in schemata to the processes of assimilation and accommodation.

ASSIMILATION

Assimilation is the cognitive process which enables the individual to integrate new information or events into existing schemata or patterns of behavior. The child tries to fit new events into the schemata he has at the time. For example, an adult points to a horse and says "What is that?" The child is seeing a horse for the first time. The child is familiar with dogs and answers: "That is a dog." According to Piaget the child, seeing the horse, sifted through his collection of schema or stimuli until he found that one that seemed appropriate to include the object. A dog has four legs and a head and for the child fits his description of a dog. The horse was therefore associated with the dog schema. Thus assimilation is the process of putting new events (horse) into already existing schema (dog).

Assimilation does not result in the change of schemata, it does affect their growth. Assimilation is merely a process that helps the person cognitively adapt to and organize the environment. Piaget attributes change of schemata to the process of accommodation.

ACCOMMODATION

Accommodation is the process which allows the individual to create new schema or modify old schema. Both of these actions results in change of schema.

ta. When confronted with a new stimulus the child tries to fit it into old schemata or to assimilate. Sometimes this cannot be done because there are no old schemata whose characteristics fit the new stimuli. The child must, therefore, accommodate or make the changes necessary. Once accommodation has taken place, once the changes have been made, the child can assimilate the stimulus. Assimilation is always the end product.

EQUILIBRIUM

The processes of assimilation and accommodation are necessary for cognitive growth and development. The amount of assimilation and accommodation that takes place is also important. If people always assimilated and never accommodated, then they would be unable to detect differences. If people always accommodated and never assimilated then they would be unable to generalize. The balance between assimilation and accommodation are as necessary as the processes themselves. Piaget calls this balance equilibrium.

SUMMARY

Upon experiencing stimuli, the child tries to assimilate the stimuli into already existing schema. If the schema is available, assimilation takes place and equilibrium, relative to the particular stimulus, results. If the child cannot assimilate the stimulus he accommodates. When accommodation is completed, assimilation can proceed and equilibrium can be attained. Cognitive growth and development proceeds in this fashion from birth throughout life at all levels of development.

FUNCTIONAL INVARIANTS

Piaget contends that heredity plays a part in cognitive development. He states that, besides neurological structures, the individual inherits functional invariants. These functional invariants account for individual differences and make the cognitive process possible. The functional invariants are the processes

of assimilation and accommodation. They come together in each individual to produce the unique way in which each individual adapts to and organizes the environment. This mode of functioning is invariant through life.

INTELLIGENCE

According to Piaget, intelligence has three components: content, structure and function. Content is the observable behavior that reflect intellectual activity. This varies between ages and individuals. Function refers to the functional invariants (assimilation and accommodation) that are stable and ongoing throughout life. Structure is the schemata that explain a particular behavior at a certain stage of development.

ACTION

Piaget stipulates that the child must "act" on the environment if cognitive development is to proceed. When children are moving, touching, looking, listening, speaking - they are acting on the environment. This means that they are taking in information to be assimilated and accommodated. Action is necessary but not a sufficient condition for cognitive development. In other words, experience alone does not ensure cognitive development, but development cannot take place without experience.

PERIODS OF DEVELOPMENT

Piaget hypothesizes that cognitive development is a process of successive qualitative changes of cognitive structures, (schemata) each structure and its change deriving from the preceding one. New schemata do not replace older ones, they incorporate them, thus a qualitative change results.

Piaget divides the process of cognitive growth into four broad periods:

1. The period of sensori-motor intelligence (0-2years). During this period behavior is mostly motoric. Conceptual thinking is not yet possible though cognitive development has started.

2. The period of preoperational thought (2 - 7 years). This period is commonly referred to as the stage of representations which is characterized by rapid language and conceptual development.
3. The period of concrete operations (7 - 11 years). This period is marked by the development of the ability to apply logical thought to concrete operations.
4. The period of formal operations (11 - 15 years). During this period cognitive structures attain the greatest level of development. The child is capable of logical thought, and applies this ability to all facets of cognitive development.

These stages are not independent stages in actual development. In addition, the ages during which children develop behavior representative of a particular stage are not fixed - these ages vary from child to child. The ages suggested by Piaget are normative and are typical for gross age groups. The onset and development of behaviors within the periods are dependent upon experience, heredity and maturation. The stages are, however, fixed and continuous. All persons develop through the same stages in the same way, but not at the same rate.

D. METHODS OF INSTRUCTION

Didactic workshop sessions are suggested as the primary method of instruction. The Piagetian theory is often a difficult one to comprehend. Consequently, the material should be presented at a very slow pace, and the content should be explained in elementary terms and many examples should be given. Time should be allotted for free and constant discussion. The student should be encouraged to ask many questions.

E. METHODS OF EVALUATION

Short, teacher developed, pencil and paper quizzes should be given after each training session. These quizzes should be used as criterion reference tests to evaluate whether or not the student has understood the content of the session.

F. LIST OF RESOURCES

Books:

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Films:

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OBJECTIVE THREE

The trainee will acquire knowledge of the eight stages of the life cycle as outlined by Erik Erikson.

A. DISCUSSION

The following is an outline of Erik Erikson's eight stages of ego development, which cover the life cycle: birth to death. These stages have both positive and negative aspects, are marked by emotional crises, and are affected both by the individual's culture and by society. Erikson stipulates that an individual's personality is developed through these eight stages. The stages are not so firmly fixed that behavior developed during one stage cannot change from stage to stage. For example, if an infant learns to mistrust, with care and positive support--mistrust can be changed to trust later on.

B. INTRODUCTORY REMARKS

Erik H. Erikson has been proclaimed America's most influential living psychoanalyst. Erikson was strongly influenced by the work of both Sigmund and Anna Freud. It was Erikson who brought Freud's psychoanalytic theory out of the confines of the nuclear family. He focused his interest on the child's entire social world - peers, teachers, and the community at large, as well as the family.

Erikson was born and spent most of his childhood years in Germany. In 1927 he was invited by Peter Blois to Vienna where he and Blois operated a school for children of Blois' patients. It is in Vienna that Erikson met Anna Freud. In 1933 Erikson and his family moved to the United States because he was offered a position at Harvard University. Erikson has been in the U. S. since that time and continues to work in the field of psychoanalysis and personality development.

C. ERIK ERIKSON: THE EIGHT STAGES IN THE LIFE CYCLE

Erikson has outlined eight stages of man's psychosocial development. According to Erikson, each of these stages brings crises. The negative and positive aspects in each crisis must be battled successfully if the next developmental stage is to be reached. In each crisis, if conditions are favorable, the positive is likely to outbalance the negative. This builds strength for the next crises. The negative is always present in the form of insecurity, anxiety, fear and immaturity.

1. Infancy: Trust versus Mistrust

One of the first tasks of infancy is to develop a sense of trust in self and the environment. Erikson contends that this sense of trust is "the cornerstone of a healthy personality." This comes from feeling good about the self and is developed through loving, consistent maternal care. The danger or crisis comes about when and if changes in maternal care takes place. Such changes may lead in the development of mistrust.

2. Early Childhood: Autonomy versus Doubt and Shame.

As children grow and their muscles develop they begin to experiment with holding on, letting go, reaching, climbing etc. They attach a great deal of importance to their physical autonomy. The problem comes if children's

growth is stimed, if they are often told to stop and deprived of the opportunity to develop autonomy. When this occurs the child develops a sense of doubt and shame and learns to expect to be defeated by those who are bigger and stronger than he is.

3. Play Age: Initiative versus Guilt

During this time children are very imaginative. They are able to move around freely. They are talkative, creative, active, curious and energetic. It is also an age during which children indulge in fantasies which lead to anxiety and guilt feelings. If this tendency to feel guilty is unwillingly encouraged by over-anxious adults children may develop the feeling that they are "bad." Such feelings may stifle initiative.

4. School Age: Industry versus Inferiority

This is the latency period during which children want to be part of their peer group. They learn to do and make things with others. Normally they learn to accept instruction and to produce. By so doing - children begin to realize their potential and seek and accept satisfaction and enjoyment from work. The danger comes when children do not have successful experiences or when they do not get recognition or social reward for their efforts. If this happens feelings of inferiority develop.

5. Adolescence: Identity versus Identity Diffusion.

This is the time of puberty during which rapid physiological and psychological changes occur. This causes children to question the consistencies and "sameness" that occurred in earlier years. The child's job during this period is to integrate childhood identifications with "biological drives, native endowment, and the opportunities offered in social roles." The danger during this period is that identity diffusion, which is a natural part of this stage of development, may result in the inability to maintain one's own identity. This is due to the fact that during the pubertal years, children are hostile to parents and other adults and are very loyal to their peer groups. This hostility versus loyalty may result in a definite attempt to become exactly the opposite of what parents want the children to become.

6. Young Adulthood: Intimacy versus Isolation

As young people begin to feel more secure in their own identity they are able to establish intimacy with themselves and others. This intimacy is identifiable in platonic relationships and in a love-based sexual relationship. Persons who cannot enter into or maintain an involved, intimate heterosexual relationship because of loss of identity fears may develop a sense of aloneness and isolation.

7. Adulthood: Generativity versus Self-Absorption

Generativity is the mature person's need and interest to procreate and to guide the next generation. Lack of this results in self-absorption and often the person feels stagnant and lacking in interpersonal skills.

8. Senescence: Integrity versus Disgust

Many persons have functioned as mature adults, able to develop mutually satisfying intimate relationships and able to accept the responsibilities, triumphs and disappointments of parenthood. Such individuals approach the end of life accepting the responsibility for their lives - their accomplishments and their mistakes. When this happens there is ego integrity. Without this "accrued ego integration" this is despair, displeasure and disgust.

D. METHODS OF INSTRUCTION

Lectures with discussion and didactic workshop sessions would be the primary methods of instruction. Since Erikson's developmental theory is partly based on the Freudian psychoanalytic theory, it may be wise to present some brief background information about Freud's work. Psychoanalyses is a detailed body of knowledge that is extremely difficult for the lay person to understand. It is neither feasible nor advisable to attempt any indepth discussion of Freud's work at this level.

E. METHODS OF EVALUATION

Short tests should be given to determine whether or not the student has understood the information presented. Interest here is primarily to determine whether or not factual information has been acquired. It would be difficult to test the ability to apply the knowledge acquired at this point.

F. RESOURCES

Books:

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OBJECTIVE FOUR

Acquire knowledge of testing strategies, a classification of tests, testing techniques, and some of the problems involved in testing.

A. DISCUSSION:

Testing of children, especially as that testing relates to minority ethnic groups, has been the cause of great concern over the past few years. Historically testing has been unfair to minority ethnic groups. Tests, that have been developed by whites and normed primarily on white middle class children have been flagrantly used to make educational judgements about all children. Often minority children have been classified as mentally retarded, learning disabled, etc. purely on the basis of these tests. That tests have been misused is an accepted fact. However, if used correctly, tests can provide valuable information about children and serve as a means of helping, not hindering children.

B. INTRODUCTION

At best any test situation is a contrived, artificial situation that evokes anxiety in the individual who is taking the test. However, tests and testers often assume that the individual taking the test is functioning to his or her best ability. Great care should, therefore, be taken to set up the total test environment so that the child is relaxed and comfortable, and anxiety is reduced. If there are any indications that the child is not able to give his/her best performance, the testing should be discontinued.

C. TESTING STRATEGIES

The following are some of the items that should be considered when testing children and some strategies that can help to make the testing situation a comfortable one.

QUALIFICATIONS OF THE EXAMINER

Most tests are developed to be used by qualified personnel. The term qualified personnel usually refers to psychologists and special educators whose academic training has included courses in testing and measurements and who have

had experience in testing. More recently, however, tests are being developed for use by the classroom teachers and paraprofessional personnel. Before a particular test is chosen careful consideration should be given to who will be administering the test.

FAMILIARITY WITH THE TEST

Perhaps the most important factor in test administration is the examiners complete familiarity with the test and test materials. It is very distracting to the child if the examiner has to learn the test and search for materials during administration of the test.

FAMILIARITY WITH THE CHILD

The examiners familiarity with the children who are to be tested is very important. The examiner should be familiar with the child's cultural and ethnic background and experiences.

PHYSICAL SETTING

The room in which the test is administered can make a significant difference in the child's performance. Ideally the room should have adequate lighting and be relatively free from distractions. If pre-school children are being tested the examiner should use a child size table and two chairs. If materials (toys, games, etc.) are being used, they should be placed in a way that is not distracting to the child.

DEVELOPING RAPPORT

The examiner should spend a few minutes on getting acquainted with the child and helping the child relax prior to the actual testing. This is especially necessary if the examiner is a stranger to the child.

ADMINISTRATION TIME

Length of time for administration of any test is dependent upon several factors. These factors include the child's ability to assimilate and accommodate new information, the way in which the child relates to the examiner and vice

versa, the examiners familiarity with the test and test materials, the child's age, and, often times, the ethnicity of the examiner. Unless the test is a speed test, the examiner should not be overly concerned with the time factor. The concern should be on getting as accurate an assessment as possible of the child's ability to perform the concepts that are being measured by the test.

INTRODUCING THE TEST

The term "test" should not be used with pre-school children. Rather, the young child should be told that you are going to play some games with him/her, and that he/she will have the opportunity to manipulate or "play with" some toys.

D. CLASSIFICATION OF TESTS

Perhaps the most influential contributors to the organization of the measurement field are Bloom and Buros. For purposes of simplifying the numerous categories of tests the following classification, based on the Bloom model is being presented. The reader is being cautioned that this classification only serves the purpose of presenting the current state of the art. A child's development cannot be divided into three separate parts. The child must be looked at as a total entity.

Cognitive Domain

- Achievement Tests
- Intelligence Tests
- Cognitive Processes Tests
- Language Tests

Psychomotor Domain

- Diagnostic Tests
- Physical Attributes Tests
- Physical Coordination Tests
- Sensory Attributes Tests

Socioemotional Domain

- Attitude Tests
- Personality Tests
- Emotional Adjustment Tests
- Vocational Interest Tests
- Behavioral Tests
- Self-concept Tests
- Social Skills Tests
- Competency Tests

E. TESTING TECHNIQUES

The following is not intended to be a thorough representation of the wide variety of testing techniques. Rather, the interest is on presenting those techniques with which an individual working in EPSDT and child development programs may come into contact.

PROJECTIVE TECHNIQUES This term is used to refer to a relatively unstructured situation in which the child uses an "unconscious" process to attribute certain attitudes, thoughts, emotions, and feelings to other persons; to attribute his own needs to others in the environment; or to draw inferences from an experience (Walker, 1973). The stimuli used include pictures, ink blots, drawings, dolls, toys and words. The most notable projective techniques test is the Rorschach Test. The focus of projective techniques is on personality.

RATING SCALES A rating scale is used to learn how someone else judges a child's behavior. Rating scales focus on describing specific observable behavior. Some examples of behavior rating scales are the classroom Behavior Inventory, the Child Behavior Rating Scale and various q-sorts.

SELF-REPORT MEASURES These usually take the form of questionnaires that are designed to measure the individual's covert behaviors and feelings. Although widely used they are problematic in that it is difficult to obtain honest answers. In addition, many of the questions are ambiguous e.g. Do you make friends easily? Are you outgoing? Some self-report measures are designed for uses with pre-school children. These require the child's response to pictures in which at least two options are presented. An example of a self-report measure is the Children's Self-Social Constructs Test.

OBSERVATIONAL PROCEDURES Observational procedures are often used with young children. Wright (1960) describes several types of observational procedures. These are: dairy descriptions -continuous observation and recording;

event-sampling-behavior recorded as the specific event of interest unfolds; time sampling - specific behavior recorded in a predetermined time span; field unit analysis - behavior divided into units and described as it occurs. Examples of observational scales are the Behavior Unit Observation and the Affectional and Aggressive Observation Checklist.

F. SOME PROBLEMS INVOLVED IN TESTING

One of the major problems in the field of testing is the credibility that is placed on test results. The results of single tests are often used to make gross generalizations about children's performance and to place life long labels on children. However, a particular instrument only assesses a child's performance on a particular day on the specific items that are included in the test.

The validity issue is another problem. In many instances, tests are constructed for the purpose of measuring affect, do not assess what they are supposed to measure. Many sociometric measures require young children to interpret verbal questions and to respond verbally. Such tests are, in actuality, assessing language and cognition, not emotion.

Another problem is the diversity and globability of some psychosocial terms such as self-concept. Many self-concept tests do not assess the same variables. This is due to the fact that self-concept is defined in a variety of different ways.

Perhaps the major problem is the fact that very few instruments have adequate standardization norms. Most tests are normed using children from one ethnic, cultural and socioeconomic group. To be representative of the general population the norm group should include a wide variety of children from varying ethnic groups, cultural backgrounds, intellectual levels, and socioeconomic backgrounds. Suffice it is to say that a test that has been normed

on one ethnic, cultural and socioeconomic group optimally should be used to assess children from that group only.

G. METHOD OF INSTRUCTION

A lecture/discussion format can be used to teach theoretical content. The student should also be given ample opportunity to observe children being tested and to practice testing each other before testing children. Even with practice, the student should be observed closely when actually testing children. In addition, immediate feedback should be given.

H. METHODS OF EVALUATION

Paper and pencil tests; observation by trainer; self and peer evaluations.

Validity checks. This can be especially used when the student is completing an observational instrument on the child. The trainer can observe the child and complete the instrument simultaneously.

I. RESOURCES

Books:

Bloom, D. (Ed). Taxonomy of educational objectives: The classification of educational goals. New York: Longmans, Green, 1956.

Bloom, B., Hastings, J., and Madaus, G. (Eds). Handbook on formative and summative evaluation of student learning. New York: McGraw-Hill, 1971.

Boger, R., and Knight, S. Social emotional task force: Final report. East Lansing: Head Start Evaluation and Research Center, Michigan State Univ., and the Merrill-Palmer Institute, 1969. (ERIC No. ED - 033-744).

Buros, O. (Ed). Personality tests and reviews. New Jersey: Gryphon Press, 1972.

Cronbach, L. Essentials of psychological testing. (2nd ed.) New York: Harper and Row, 1960.

Freeman, F. Theory and practice of psychological testing. (3rd ed.) New York: Holt, Rhinehart and Winston, 1962.

Henry, W. Projective techniques. In P.H. Mussen (Ed.), Handbook of research methods in child development. New York: Wiley, 1960.

Horrocks, J. and Schoonover, T. Measurement for teachers. Ohio: Charles E. Merrill, 1968.

Johnson, O. and Bommarito, J. Tests and measurements in child development: A handbook. San Francisco: Jossey-Bass, 1971.

Murstein, B. (Ed.) Handbook of projective techniques. New York: Basic Books, 1965.

Walker, D. Socioemotional measures for preschool and kindergarten children. San Francisco: Jossey-Bass, 1973.

OBJECTIVE FIVE

Learn to administer specific assessment instruments.

A. DISCUSSION

It is beyond the scope of this manual to suggest specific testing instruments. Rather, listed in this section are sources that evaluate a variety of tests. The primary pre-school assessment instrument used in the NCDCA/EPST program was the Developmental Systems Analysis (DSA). The DSA is co-authored by James Ballard, Ph.D., Yvonne Brunton Ali, Ph.D., and other staff members of the NCDCA-EPST program.

The DSA was developed because of a felt need for an instrument which would be acceptable to the Black community, acceptable to the staff who had to administer the instrument, and which would allow for as fair and accurate assessment of the population as possible.

The DSA is one of very few tests developed by Blacks and normed on a Black population for use with Black children. It is consequently felt to be an effective screen for Black children. This, however, does not preclude its use by other groups. It is simply that any other reference group using the instrument should make the same kind of allowances that have been made by Blacks when they used tests that have been normed on predominantly White groups.

The DSA is composed of seven subsections which are designed to assess the developmental level of preschool children in the following areas: cognition, language, visual-motor, memory, gross-motor, personal-social and emotional.

Each of the seven sub-sections is constructed so that it can be administered individually as well as in aggregate.

The DSA test manual, kit, score sheets and therapeutic analysis forms are available through the National Child Day Care Association - 1501 Benning Road, Northeast, Washington, D.C. 20002. Attention: Yvonne B. Ali, Ph. D.

B. REFERENCE SOURCES

Buros, O. (Ed) The first through the eighth mental measurement yearbooks. New Jersey: Gryphon Press.

Center for the Study of Evaluation. Elementary school test evaluations. California: UCLA Graduate School of Education, 1970.

Center for the Study of Evaluation and Early Childhood Research Center. Preschool kindergarten test evaluations. California: UCLA Graduate School of Education, 1971.

Mouly, G and Walton, L. Test items in education, New York: McGraw-Hill, 1962.

Walker, D. Socioemotional measures for preschool and kindergarten children. San Francisco: Jossey-Bass Publishers, 1973.

OBJECTIVE SIX

Become familiar with some of the terms commonly used in the field of child development.

DISCUSSION

Included in the emotional section of this manual are definitions of many of the terms that are used in child development. The reader is referred to that section for a more complete glossary.

GLOSSARY OF TERMS USED IN CHILD DEVELOPMENT

Primary Source:

Comprehensive Textbook of Psychiatry/II (Vol. 2) edited by Alfred M. Freedman, Harold I. Kaplan and Benjamin J. Saddock.

Abstract thinking:	The ability to generalize thinking and formulate ideas that are not directly related to concrete experiences or materials. Children do not acquire the ability to think abstractly until they are approximately 6 - 7 years of age, or in the Piagetian framework in the period of concrete operations.
Alexia:	Inability to understand the meaning of printed words and sentences.
Amentia:	Inability to develop intellectually because of inadequate brain tissue.
Aptitude tests:	Tests that are used to evaluate a person's interests and skills.
Average:	A central value around which other values are distributed - most frequently used term is the mean.
Behavior Modification Approach	An instructional model based on the principles of behavior modification proposed by B.F. Skinner. The major objective is to change overt negative behaviors by providing rewards when the acceptable behavior occurs.
Cognition:	Thinking - the mental processes of knowing, learning and becoming aware.
Creativity:	The ability to produce something new.
Decoding:	A mental process by which the individual is able to understand the meaning of the printed or spoken word.
Down's Syndrome:	A type of mental retardation. Often referred to mongolism because of the physical appearance of the individual. A person suffering from mongolism is often referred to as mongoloid.

Dyslexia:	A reading disability in which the person is unable to understand the printed word. This disability is not related to intelligence.
Early Childhood:	The childhood period between one through six years of age. Marked by tremendous activity and learning.
Echolalia:	Repetition of another person's words or phrases.
Egocentric:	Often used to refer to a person who is selfish and preoccupied with his own needs. According to Piaget, young children are naturally egocentric. To the child all actions are events that revolve around him.
Encode:	The ability to translate the written or spoken word into the particular language of your own brain.
Formal Operations:	Jean Piaget's label for the stage of development reached when the individual is capable of logical thinking.
Gifted:	An individual whose intellectual capacity is above average.
Habit:	A repetitious learned response - thumb sucking is probably the most common habit in young children.
Infancy:	The first year of life, marked by helplessness and dependency.
Intelligence:	Capacity for understanding, recalling, and integrating what one has learned and using it to meet new situations.
Intelligence Quotient:	IQ: An individual's score on an intelligence test. A measure of intelligence that is calculated as follows: Mental Age/Chronological Age X100.
Learning Disabled:	Inability of an individual to learn at the same rate as his normal peers. Said to be caused by a malfunctioning of the brain. This condition is not related to intelligence.
Memory:	Ability to remember or revive past experiences, ideas and material.

Mental Age:	M.A. - A measure of mental ability based on psychological tests.
Mental Retardation:	Below average intellectual functioning that may be evident at birth, occur during early childhood or occur as a result of severe injury.
Operant Conditioning:	A term used to describe the process by which negative behavior changes as a result of reinforcing positive behavior. The term was introduced by B. F. Skinner.
Perception:	The mental process by which cognitive, emotional and sensory materials are meaningfully organized.
Screening:	Initial evaluation or assessment.
Slow Learner:	The inability of an individual to learn at the same rate as other children of the same age: generally said to be caused by malfunctioning of the brain, or inadequate cultural and experiential background.
Under-Achiever:	An individual who is not functioning intellectually up to his or her capacity. Usually caused by emotional problems or poor education.



I leave you finally a
responsibility to our young
people for they are to be
the leaders of tomorrow.

May He Lead Bethune.

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